OPIOID NEEDS ASSESSMENT

Idaho

October 2017

Prepared by: Idaho Department of Health and Welfare, Division of Behavioral Health
as a Component of Idaho's Response to the Opioid Crisis Project

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Idaho's Response to the Opioid Crisis

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Contents

Note to the Reader

In this assessment, we compiled data from throughout the literature and various data source systems. We strove to present the most current available data from a thorough array of sources to develop the most complete and accurate picture possible of Idaho's opioid crisis. Consequently, our data represents a variety of time periods, depending on what was available from the data source. We recognize this as a limitation and encourage the reader to take note of dates when examining figures and to consider these variations when making comparisons.

Executive Summary

- **Indicators of Heroin and Non-Heroin Opiate/Synthetic Use, Misuse, and Dependence**
  - Since reaching a peak in 2010-2012, several indicators appear to show a modest decrease in non-heroin opiate/synthetic use in Idaho over recent years.
  - However, in 2016 Idaho was above the national average for the rate of opioids dispensed per 100,000 population and many indicators suggest that Idaho has experienced a significant increase in heroin use over the past decade.
- **Drug Overdoses and Opioid-Related Mortality**
  - The most recent data available regarding drug overdose deaths appears to show that while rates have increased in Idaho since 2010, Idaho remains slightly lower than the national average. In 2015, Idaho ranked 34th in the age-adjusted rate of drug overdose deaths by state.
  - It is estimated that more than half of all drug deaths were associated with an opioid (62.0%).
  - However, statewide the types of drugs involved with drug-induced deaths are underreported on death certificates and thus the true number of opioid-involved overdose deaths is likely higher than what is observed through analysis of vital records.
- **Gaps in Treatment and Services**
  - The current substance abuse prevention system in Idaho to address the opioid crisis is a collaborative, multi-disciplinary effort aimed at employing evidence-based prevention strategies and public policy initiatives. It has many strengths including the use of a variety of evidence-based practices in prevention education.
  - However, it is clear there is still room to improve prescribing practices, especially in Frontier counties. Frontier counties, in particular, may be at risk for opioid overprescribing and could warrant special consideration when planning a response to Idaho's opioid crisis.
  - Adolescents and young adults in Idaho are an important high-risk population for heroin and non-heroin opiate/synthetic use, misuse, and dependence. Attention should be provided to education addressing middle school and early-high school students and their families, as the period between 10th and 11th grade appears to be a critical time for adolescents in Idaho to begin using prescription drugs without a doctor's prescription. Attention should also be directed towards improving prevention strategies aimed at Idahoans aged 18-25, a group which has been historically shown to be difficult to reach, especially those who do not choose to attend a university.
  - Although higher past 30-day use of prescription drugs was not seen among this demographic, a significantly greater percentage of Hispanics report that there is no or slight risk in using prescription drugs not prescribed by a licensed medical provider. As such, prevention strategies should be culturally competent and tailored to Idaho's Hispanic population.
  - Over half of Idaho's substance abuse prevention workforce is over the age of 45, which emphasizes a great need for recruitment.
  - Accessing MAT using public funding is difficult in Idaho. However, a recently acquired SAMHSA grant will introduce publicly-funded MAT to Idaho by adding Methadone and Suboxone to the array of treatment and recovery support services that are currently available.

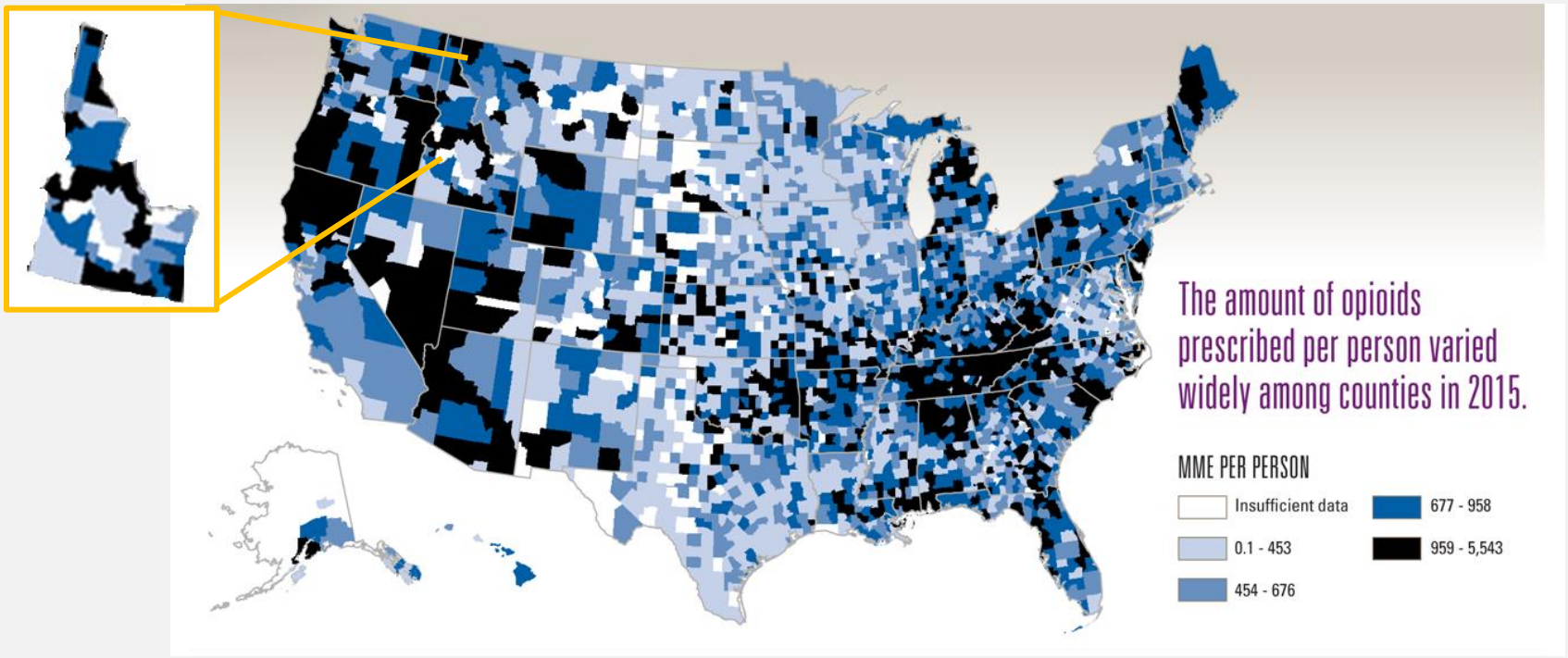
While Idaho is most definitely experiencing a significant increase in opiate and heroin use, misuse, and death, the opiate epidemic here has not yet reached the proportions that other states in the Midwest and East Coast are facing. Thus, coordinated efforts to combat this epidemic are just now coming to fruition in this state.

I. Prescribing and Dispensing Opioids in Idaho: The Most Recent Available Data Obtained from Idaho's Prescription Drug Monitoring Program (PDMP)

- To gather data regarding prescribing practices, the Board of Pharmacy currently utilizes Unsolicited Reports that are sent to prescribers and pharmacies who have patients exceeding the monthly threshold.
- The Board is working to launch Prescriber Report Cards, which will help prescribers identify how their prescribing habits compare to others in the same specialty.

i. Prescribing Opioids in Idaho

Opioids Prescribed (in Morphine Milligram Equivalents, MME) per Person; Centers for Disease Control and Prevention (2015)

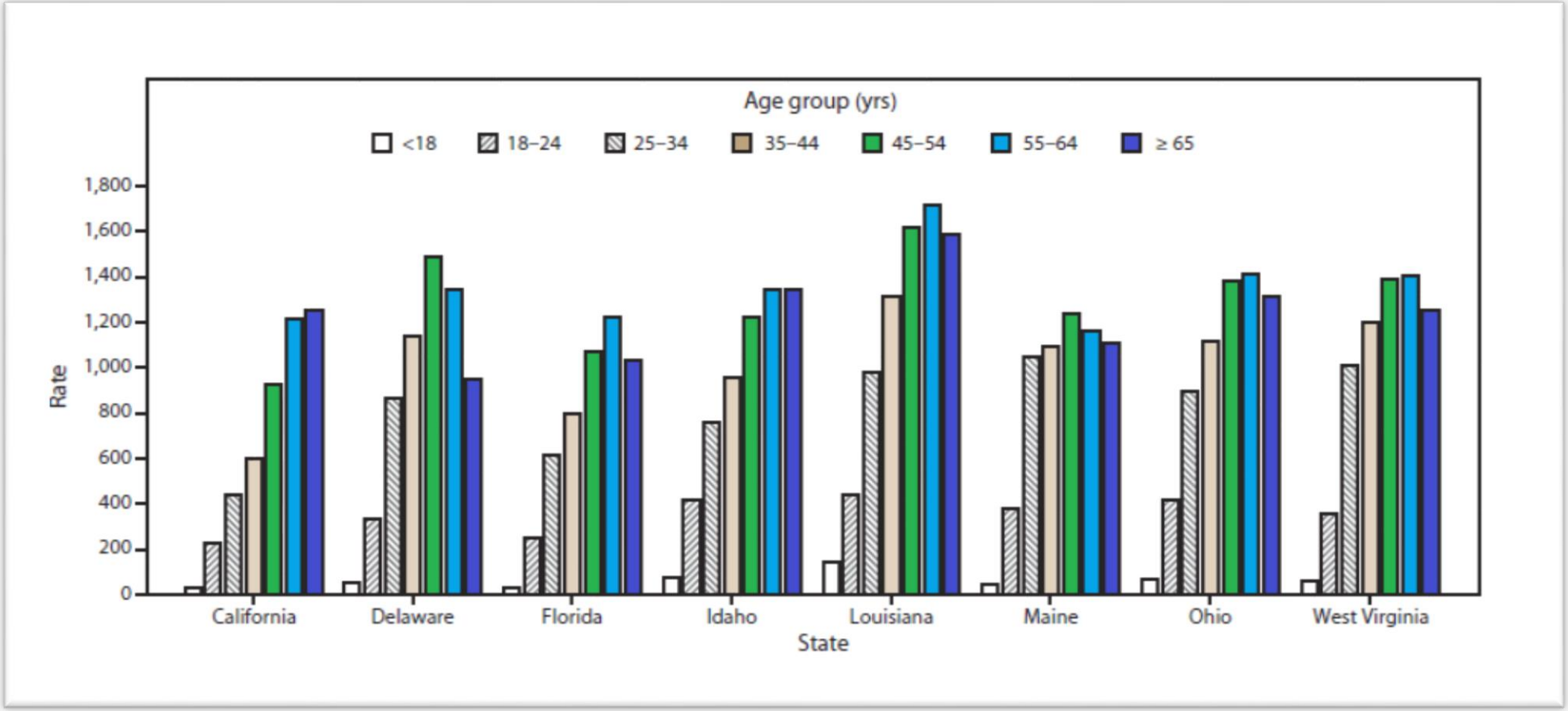


Higher opioid prescribing puts patients at risk for addiction and overdose. Following national trends, Idaho saw a wide variation in opioid prescribing among counties in 2015, suggesting a lack of consistency among providers when prescribing opioids.

- The CDC classified 13 of Idaho's 44 counties (29.5%) in their highest category of opioids prescribed per person (959-5,543 MME per person) including: Boundary, Shoshone, Nez Perce, Washington, Gem, Valley, Lemhi, Butte, Twin Falls, Cassia, Oneida, Bear Lake, and Caribou.
- Of these 13 counties:
  - 8 (61.5%) are frontier (less than 7 persons per square mile).
  - 5 (38.5%) are rural (less than 100 persons per square mile).
  - Overall, 22 (50%) of Idaho's 44 counties are rural, while 19 (43.2%) of counties are frontier. As such, frontier counties appear to be over-represented among those with high amounts of opioids prescribed per person.

Centers for Disease Control, CDC Vital Signs, July 2017; United States Census Bureau, American FactFinder, 2015

Prescribing Rates per 1,000 State Residents, by Age Group, Compared to Seven Other States[1]; Prescription Behavior Surveillance System/Centers for Disease Control and Prevention (2013)

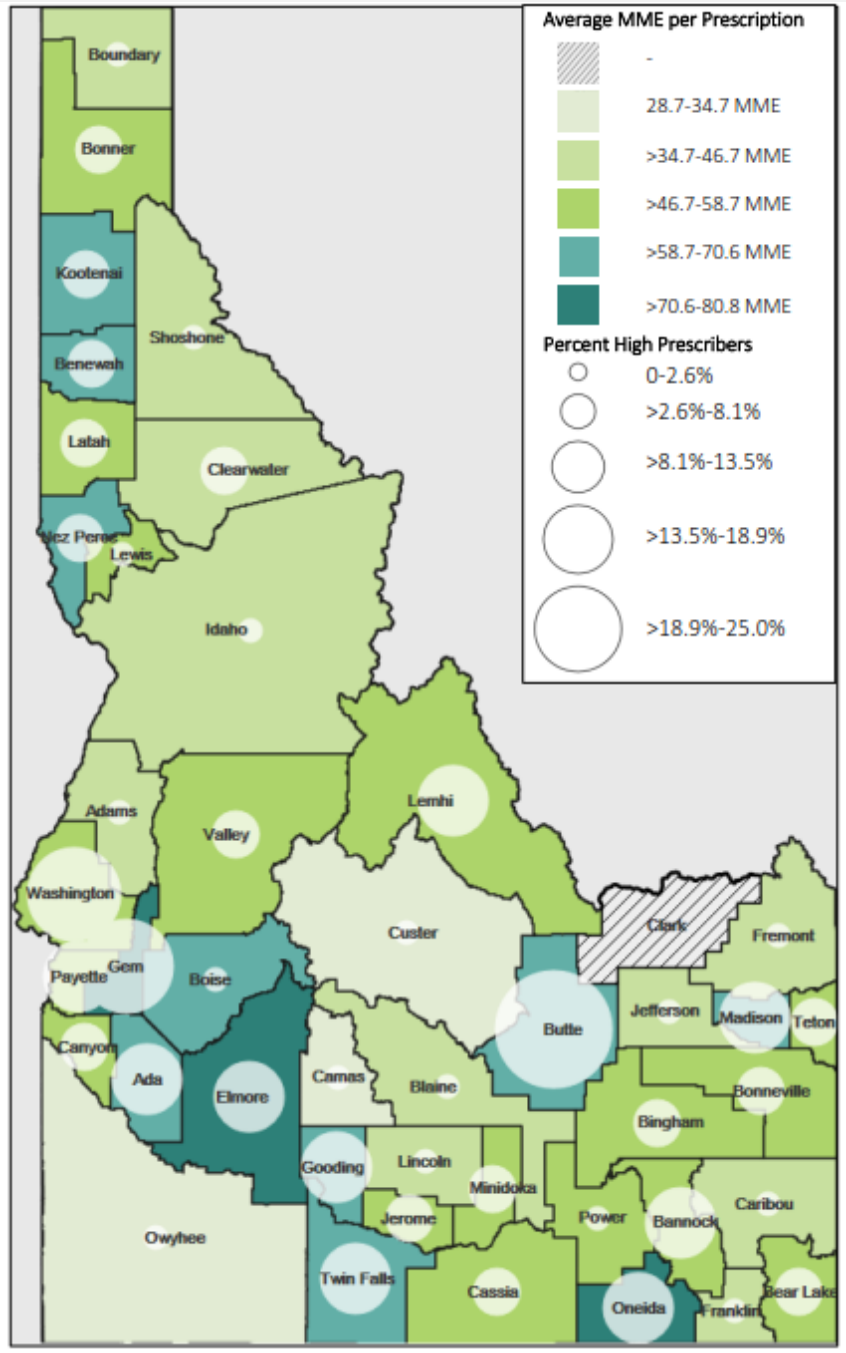


The CDC observed that opioid prescribing rates increased steadily with age in Idaho, unlike 6 other states where rates were highest in middle-aged persons. The trend seen in Idaho is consistent with a general increase in the prevalence of chronic pain with age. However, SAMHSA recently showed an increase in opioid misuse among older adults (age 50+) in The CBHSQ Report (Opioid Misuse Increases Among Older Adults; July 25, 2017), with opioid misuse among older adults increasing nationally from 1.1% in 2002 to 2.0% in 2014. As such, future monitoring of this trend and age group may be warranted.

Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report (MMWR), 2013

[1]These states were selected for representation because they provided complete quarterly data to the Prescription Behavior Surveillance System for 2013 and routinely collect data on every prescription for a controlled substance to help law enforcement and health care providers identify misuse or abuse of such drugs. The Prescription Behavior Surveillance System (PBSS) is a public health surveillance system that allows public health authorities to characterize and quantify the use and misuse of prescribed controlled substances. PBSS began collecting data in 2012 and is funded by CDC and the Food and Drug Administration.

Schedule II Opioids: Average Morphine Milligram Equivalents (MME) per Prescription per Prescriber per County and Percent High Prescribers per County (2015-2016)



On average Idaho clinicians prescribed 53 daily MME per schedule II opioid prescription between ’15 and ’16.

This map shows the average morphine milligram equivalents per prescription per clinician per county and the percentage of clinicians who prescribed an average of 100 daily MME per schedule II opioid prescription per county among those that prescribed a schedule II opioid between 4/1/2015 and 3/31/2016.

- On average, clinicians in Gem County, Elmore County, and Oneida County wrote schedule II opioid prescriptions for a significantly higher number of average daily MMEs per prescription when compared to the other counties.
- Approximately 5% of clinicians in Idaho prescribe an average of more than 100 daily MMEs per schedule II opioids prescription.
- Butte County, Gem County, and Washington County had a significantly higher percentage of clinicians who prescribed on average 100 MMEs or more per schedule II opioid prescription.
- There were no clinicians in Clark County that prescribed a schedule II opioid between 4/1/2015-3/31/2016.
- However, it is important to note that drawing conclusions based on the percent of high prescribers per county is difficult in Idaho as the small number of prescribers in many counties can cause even one high prescriber to drastically change the county’s rate.

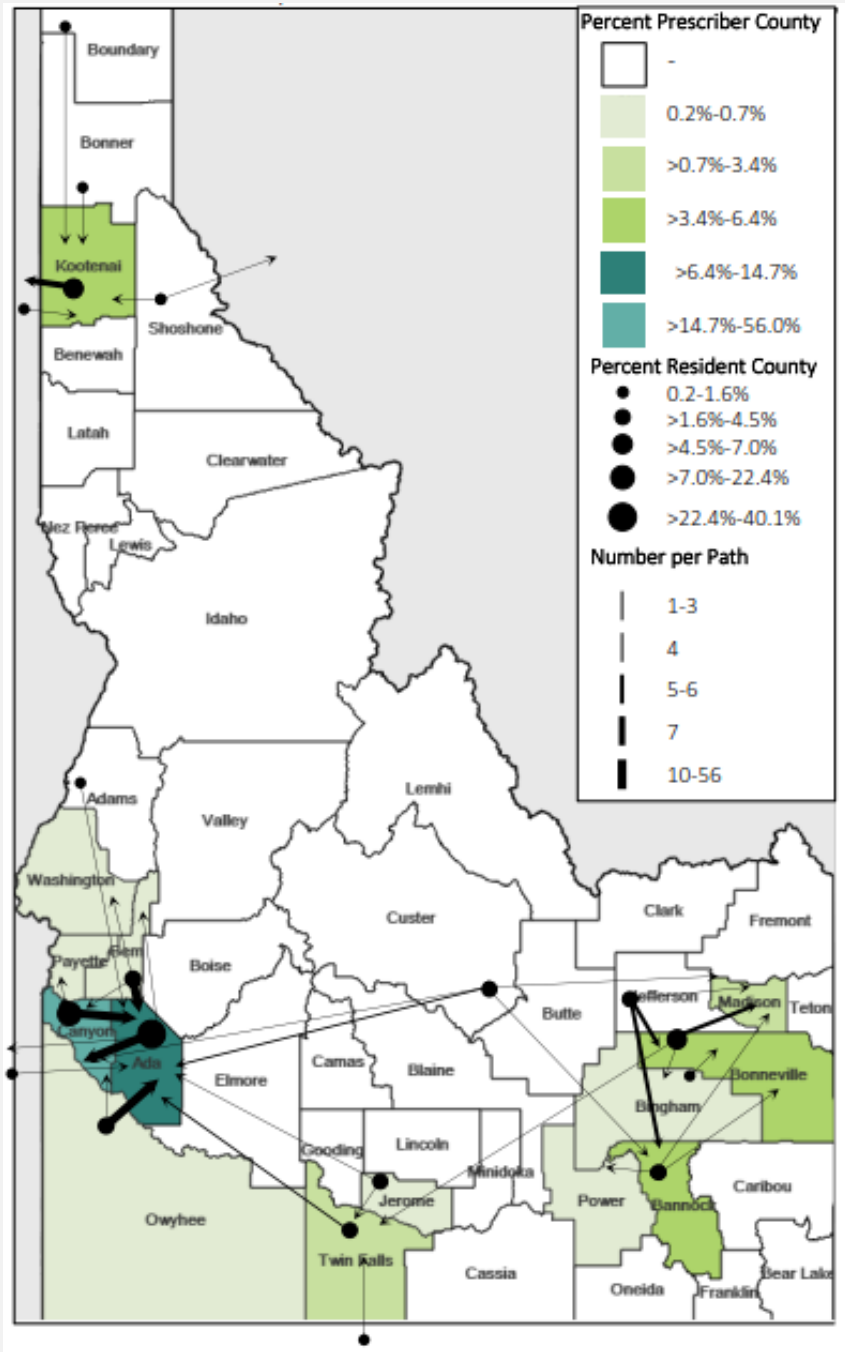
Idaho Board of Pharmacy, Prescription Drug Monitoring Program, 4/1/2015-3/31/2016; Idaho Office of Drug Policy, Opioid Needs Assessment

Schedule II Opioids: Multiple Provider Episodes (2015-2016)

Between ’15 and ’16, there were 41 individuals that met the criteria for having multiple provider episodes.

Only data from schedule II opioid prescriptions filled by someone who met the criteria for multiple provider episodes (MPE) between 4/1/2015 and 3/31/2016 are included in this map. According to the Centers for Disease Control and Prevention, the definition of MPE is obtaining a prescription from five or more prescribers and filling those prescriptions at five or more pharmacies in the past six months. This map shows the percentage of episodes in which individuals who met the criteria for MPE obtained a prescription from a prescriber in each county; the percentage of episodes in which individuals who met criteria for MPE reported he or she was a resident of each county; and the number of episodes in which a person who met criteria for MPE traveled from their resident county to a different county to see a prescriber to obtain a schedule II opioid.

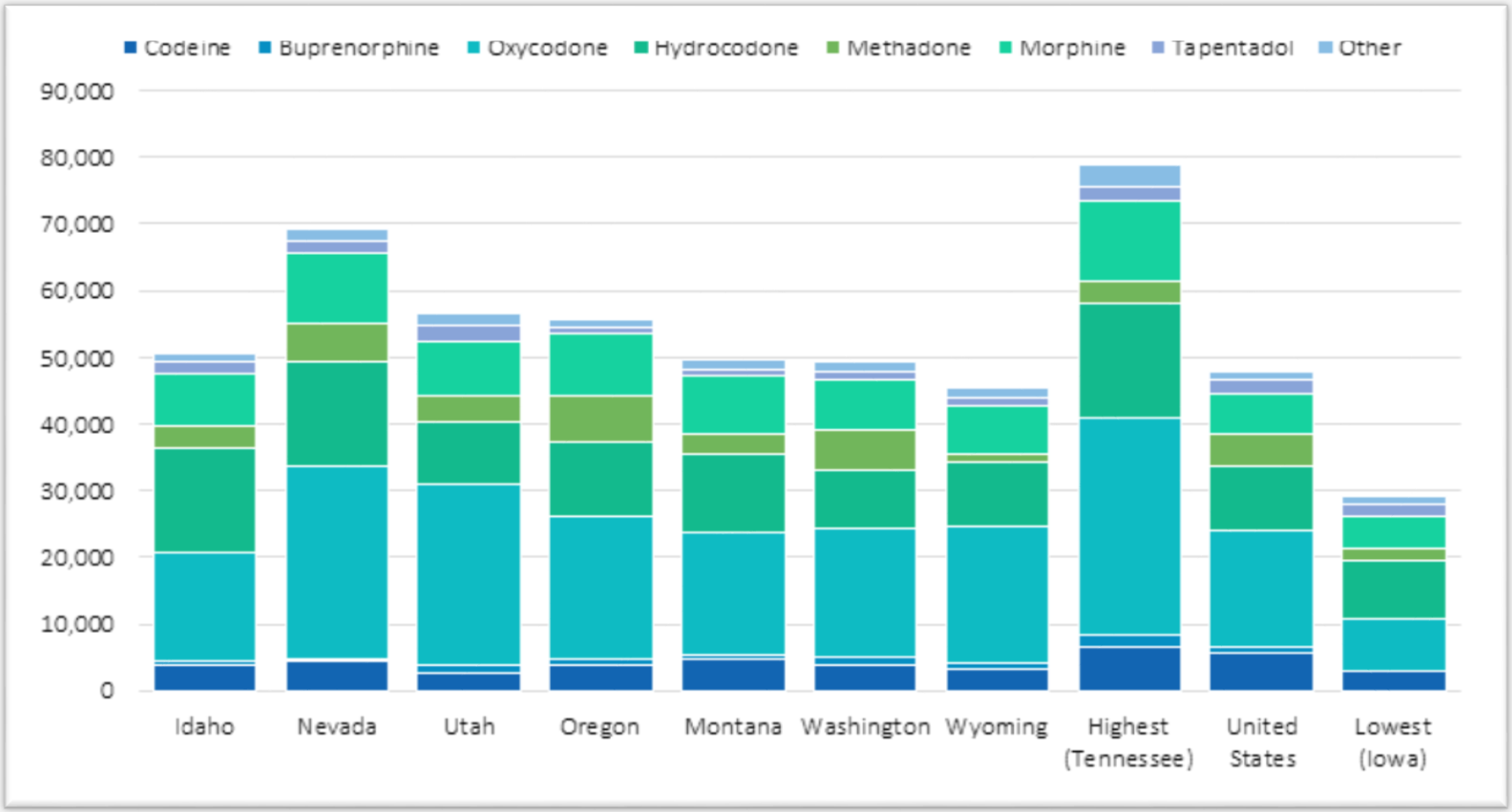
- Over 80% of those that met the criteria for MPE were women, 34% were between the ages of 26 and 35, and 27% reported being from a different county or state during at least one episode.
- One individual reported being a resident of four different counties during a nine-month period.
- Among these 41 individuals, there were 434 schedule II opioids prescriptions filled between 4/1/2015 and 3/31/2016.
- 56% of schedule II opioid prescriptions that were filled by individuals who met criteria for MPE were prescribed in Ada County.
- Over 40% of episodes in which the schedule II opioids were filled to individuals who met criteria for MPE reporting being a resident of Ada County.
- The most common path from patient to prescriber among those that met the criteria for MPE was from Ada County to Canyon County.
- Madison County, Washington County, Payette County, and Power County did not have residents who met the criteria for MPE; however, those counties were ones in which MPE patients traveled to, to see physicians for a schedule II opioid prescriptions.
- Boundary County, Bonner County, Shoshone County, Custer County, Jefferson County, and Adams County all had residents that met the criteria for MPE, but those individuals did not obtain any of their schedule II opioid prescription from prescribers in their resident county.



Idaho Board of Pharmacy, Prescription Drug Monitoring Program,4/1/2015-3/31/2016; Idaho Office of Drug Policy, Opioid Needs Assessment

ii. Distribution of Opioids in Idaho

Opioids Dispensed (in grams) per 100,000 Population in Idaho; Compared to Neighboring States, the Highest, and Lowest States for Opioids Dispensed (in the United States), and the US National Average (2016)



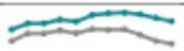
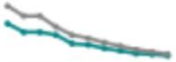
In 2016, Idaho was above the national average for the rate of opioids dispensed per 100,000 population.

The state had a slightly higher ratio of Hydrocodone to Oxycodone than other nearby states and the national average.

Cumulative Distribution by State in Grams per 100,000 Population (Run date: 2/3/2017). Automation of Reports and Consolidated Orders System (ARCOS), Drug Enforcement Administration, 2016

*ARCOS is a database of controlled substance transactions destined for pharmacies, hospitals, or physicians' offices, collected from manufacturers and distributors and reported to the Drug Enforcement Administration (DEA). The rates reported above are based on population estimates in 2010.

Opioid Retail Distribution, in grams (2006-2016)

	2016			Trend
	Rank	Grams per 100,000 Population		(2006-2016)
		ID	USA	
FENTANYL	8	172.36	126.10	
MORPHINE	12	7,979.98	6,132.73	
REMIFENTANIL	13	0.57	0.51	
HYDROMORPHONE	20	526.05	508.69	
HYDROCODONE	9	15,620.02	9,707.84	
OXYMORPHONE	25	432.83	500.05	
TAPENTADOL	29	1,577.43	1,990.47	
BUPRENORPHINE	32	774.79	957.12	
OXYCODONE	38	16,250.12	17,510.70	
OPIUM POWDERED	26	11.57	10.62	
ALFENTANIL	3 (2015)	0.34	0.12	
DIHYDROCODEINE	9	13.59	10.56	
METHADONE	37	3,259.57	4,643.49	
MEPERIDINE (PETHIDINE)	25	237.75	278.31	
CODEINE	33	3,775.10	5,571.32	

The retail distribution of fentanyl in Idaho is above the national average and has increased since 2006.

The Automation of Reports and Consolidated Order System (ARCOS) is a database of controlled substance transactions destined for pharmacies, hospitals, or physicians' offices, collected from manufacturers and distributors and reported to the Drug Enforcement Administration (DEA).

This table shows the retail distribution of grams of common opioid prescriptions per 100,000 population, Idaho's current rank, and the trend of distribution over time.

- The distribution of fentanyl, morphine, remifentanil, hydrocodone, and alfentanil are above the national average.
- Since '06, the distribution of all prescription opioids except powdered opium, alfentanil, dihydrocodeine, methadone, meperidine, and codeine has increased.
- In 2016, Idaho ranked 3rd and 8th among US states and territories for the retail distribution of alfentanil and fentanyl, respectively.
- In 2016, the drug with the highest number ofgrams per 100,000 distributed in both Idaho and the United states for an opioid was oxycodone

Cumulative Distribution by State in Grams per 100,000 Population, Automation of Reports and Consolidated Order System, Drug Enforcement Administration, U.S. Department of Justice; Idaho Office of Drug Policy, Opioid Needs Assessment

II. Opioid-Related Mortality in Idaho: The Most Recent Data Available for Opioid-Involved Overdose Deaths

- In Idaho, death certificates for drug-induced deaths may report one drug, more than one drug, or no drugs (i.e. only states "accidental drug overdose").

- The type of drug(s) involved with drug-induced deaths are underreported throughout the state. Certain counties (including some of Idaho's largest counties, such as Bonneville and Canyon county) have a particularly large percentage of drug deaths with no drug(s) specified on the death certificate.

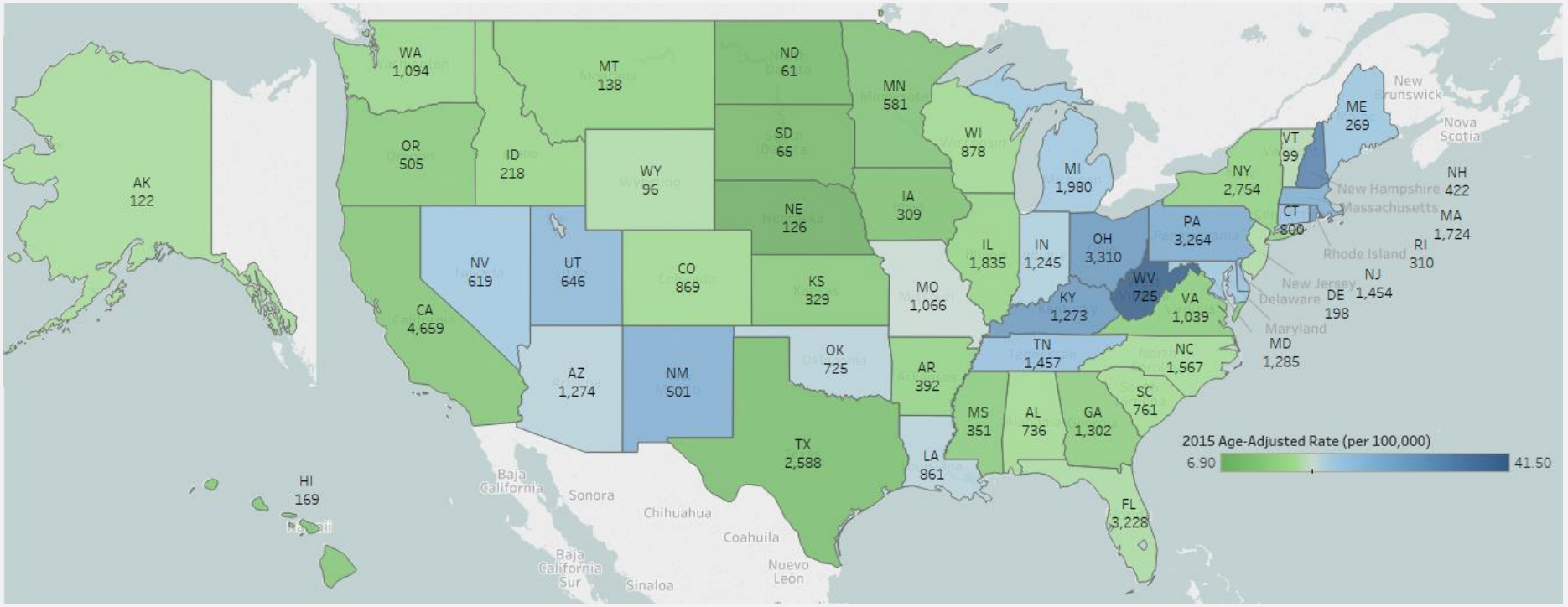
- Consequently, the number of true opioid-involved overdose deaths is likely higher than what is observed here.

- The lack of standard and consistent reporting of drug-induced deaths across the state also makes comparing rates across counties difficult. As well, drawing conclusions based on the rate of opioid-involved overdose deaths is problematic in Idaho as the small population size of many counties can cause even one death to drastically change the county's rate. As such, population-standardized rates are not presented.

- Reported deaths are based on the decedent's county of residence. The death may have occurred in their county of residence, in another county in Idaho, or out of state.

i. Drug Overdose Deaths in Idaho

Number and Age-Adjusted Rates of Drug Overdose Deaths by State (2015)



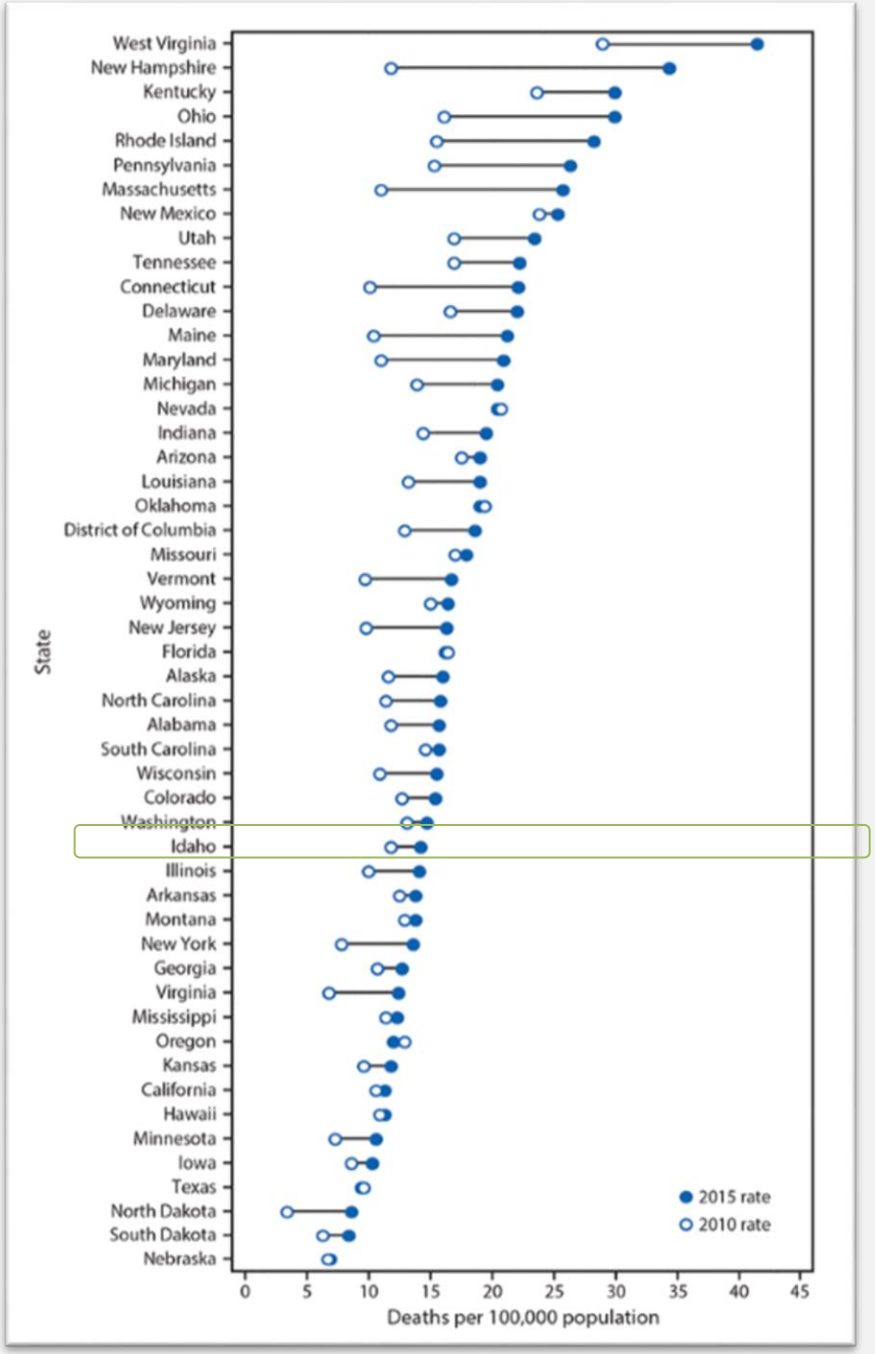
Per the Centers for Disease Control and Prevention, Opioids (both prescription and illicit) are the main driver of drug overdose deaths throughout the United States. Opioid overdoses have quadrupled nationally since 1999. In 2015, Opioids were involved in 33,091 deaths across the country.

218 Idahoans died from overdoses in 2015, with more than 60 percent of these deaths attributed to prescription painkillers and opioids. This number rose slightly from 207 and 212 deaths in 2013 and 2014, respectively.

Age-adjusted rates are rates that would have existed if the population under study had the same age distribution as the "standard" population. Age adjusting rates is a way to make fairer comparisons across groups with different age distributions. In this case, the standard population is the 2000 U.S. Standard Population. The age-adjusted rate of drug overdose deaths increased from 13.4 per 100,000 in 2013 to 13.7 in 2014 and was last reported by the CDC as 14.2 per 100,000 in 2015. However, despite the observed progressive increase in Idaho's drug overdose death rate, it remains lower than the national average of 17.8 per 100,000 in 2015.

CDC/NCHS, National Vital Statistics System, Mortality, 2013-2015

Change in Age-Adjusted Rates of Drug Overdose Deaths by State (2010-2015)



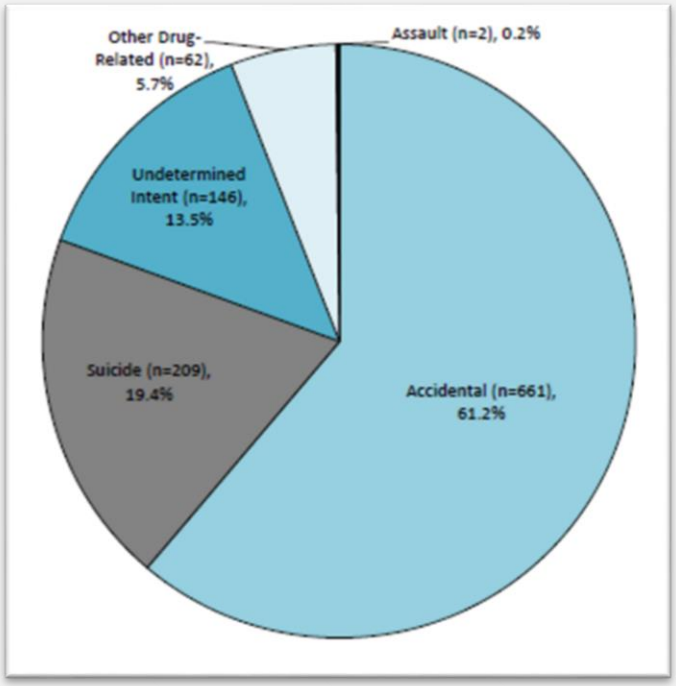
Rates shown are the number of deaths per 100,000 population. Age-adjusted death rates were calculated by applying age-specific death rates to the 2000 U.S. standard population age distribution.

Nationally, Idaho has the 34th highest age-adjusted rate of drug overdose deaths (14.2 per 100,000 in 2015). Idaho saw a significant increase in the rate of drug overdose deaths between 2010 and 2015, yet remains slightly below the national average rate of 17.8 per 100,000 observed in 2015.

Centers for Disease Control and Prevention, National Vital Statistics System, Mortality, CDC Wonder, 2010-2015

Percent of Drug-Induced Death by Manner of Death (as specified by ICD-10 code, 2011-2015)

The majority (61.2%) of drug-induced deaths in Idaho are categorized as accidental, with suicides comprising just less than one-fifth of deaths (19.4%).

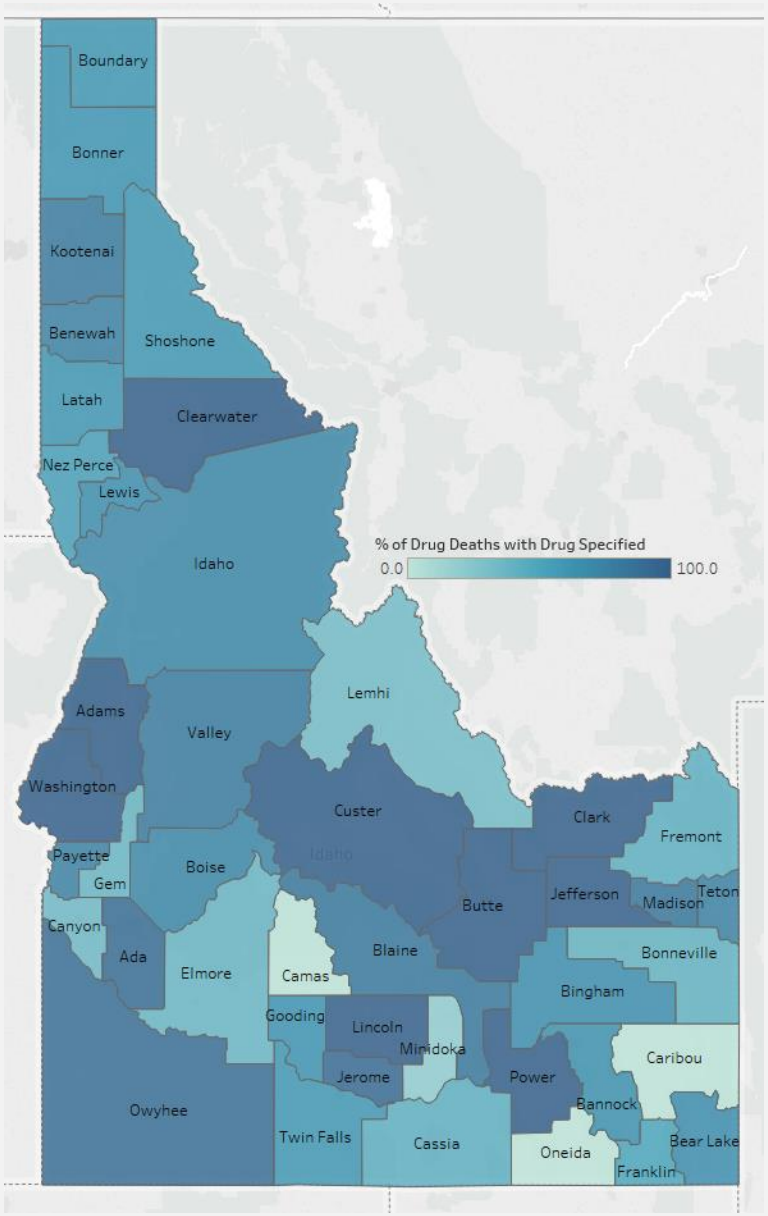


Drug-Induced Deaths: Idaho Residents, 2011-2015; Division of Public Health (July 2017)

Percent of Drug-Induced Deaths with a Drug Specified by State and County (2012-2016)

In 11 Idaho Counties, more than half of drug-induced deaths did not have a drug specified: Bonneville, Camas, Canyon, Caribou, Cassia, Elmore, Fremont, Gem, Lemhi, Minidoka, and Oneida.

- However, Camas, Caribou, and Oneida counties also had just one drug death each during the observation period.
- Of note, all of these counties are located in the southern portion of the state, with most in the southeast region.



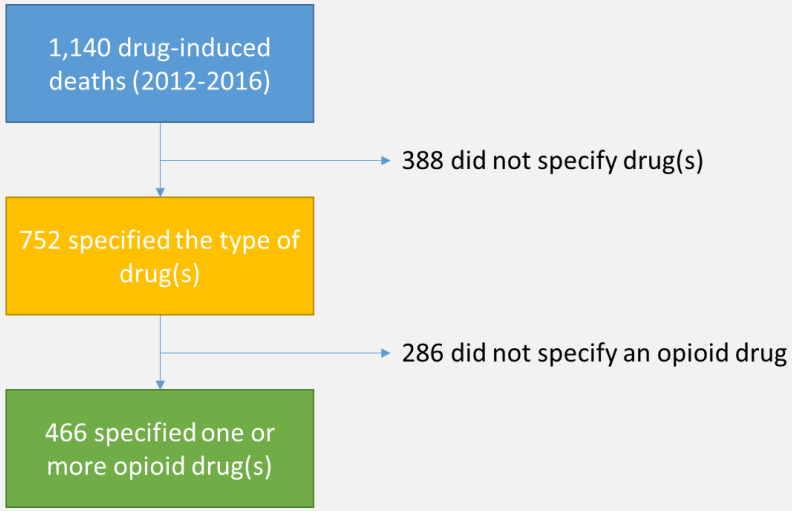
[1]County of residence may or may not be the county death occurred.
[2]Drug-Induced deaths include drug deaths due to natural (chronic drug use), and drug poisoning by accident, suicide, homicide, and undetermined intent of injury.
[3]Decedents may have none, one, or more than one drug specified on the death certificate.
[4]Opioids Include Opium, Heroin, Natural and semisynthetic opioids, Methadone, Synthetic opioids other than methadone, and other and unspecified narcotics (i.e. "opioid" not specified).

Bureau of Vital Records and Health Statistics; Division of Public Health (July 2017)

County of Residence[1]	Number of Drug-Induced Deaths[2]	Number of Drug-Induced Deaths with At Least One Drug Specified On Death Certificate[3]	Percent of Drug-Induced Deaths with Drug Specified
Ada	289	263	91.0%
Adams	1	1	100.0%
Bannock	104	67	64.4%
Bear Lake	6	4	66.7%
Benewah	8	6	75.0%
Bingham	30	20	66.7%
Blaine	11	9	81.8%
Boise	7	5	71.4%
Bonner	21	13	61.9%
Bonneville	146	59	40.4%
Boundary	10	6	60.0%
Butte	2	2	100.0%
Camas	1	-	0.0%
Canyon	115	41	35.7%
Caribou	1	-	0.0%
Cassia	7	3	42.9%
Clark	1	1	100.0%
Clearwater	3	3	100.0%
Custer	1	1	100.0%
Elmore	13	5	38.5%
Franklin	12	6	50.0%
Fremont	7	3	42.9%
Gem	13	5	38.5%
Gooding	8	5	62.5%
Idaho	7	5	71.4%
Jefferson	8	8	100.0%
Jerome	12	11	91.7%
Kootenai	80	64	80.0%
Latah	18	11	61.1%
Lemhi	9	3	33.3%
Lewis	3	2	66.7%
Lincoln	4	4	100.0%
Madison	6	5	83.3%
Minidoka	15	3	20.0%
Nez Perce	27	15	55.6%
Oneida	1	-	0.0%
Owyhee	9	8	88.9%
Payette	29	22	75.9%
Power	7	7	100.0%
Shoshone	15	9	60.0%
Teton	4	3	75.0%
Twin Falls	58	35	60.3%
Valley	10	8	80.0%
Washington	1	1	100.0%
Total	**1,140**	**752**	66.0%

ii. Opioid-Involved Drug Overdose Deaths in Idaho

Opioid-Involved Overdose Deaths in Idaho (2012-2016)



- There were 466 drug-overdose deaths in Idaho with opioid drug(s) specified on the death certificate from 2012-2016.
- Among drug-induced deaths in which at least one drug was specified on the death certificate, 62.0% reported one or more opioid(s).
- As previously described, the true number of opioid-involved overdose deaths is likely much higher due to underreporting of the type of drug(s) involved with drug-induced deaths throughout the state.

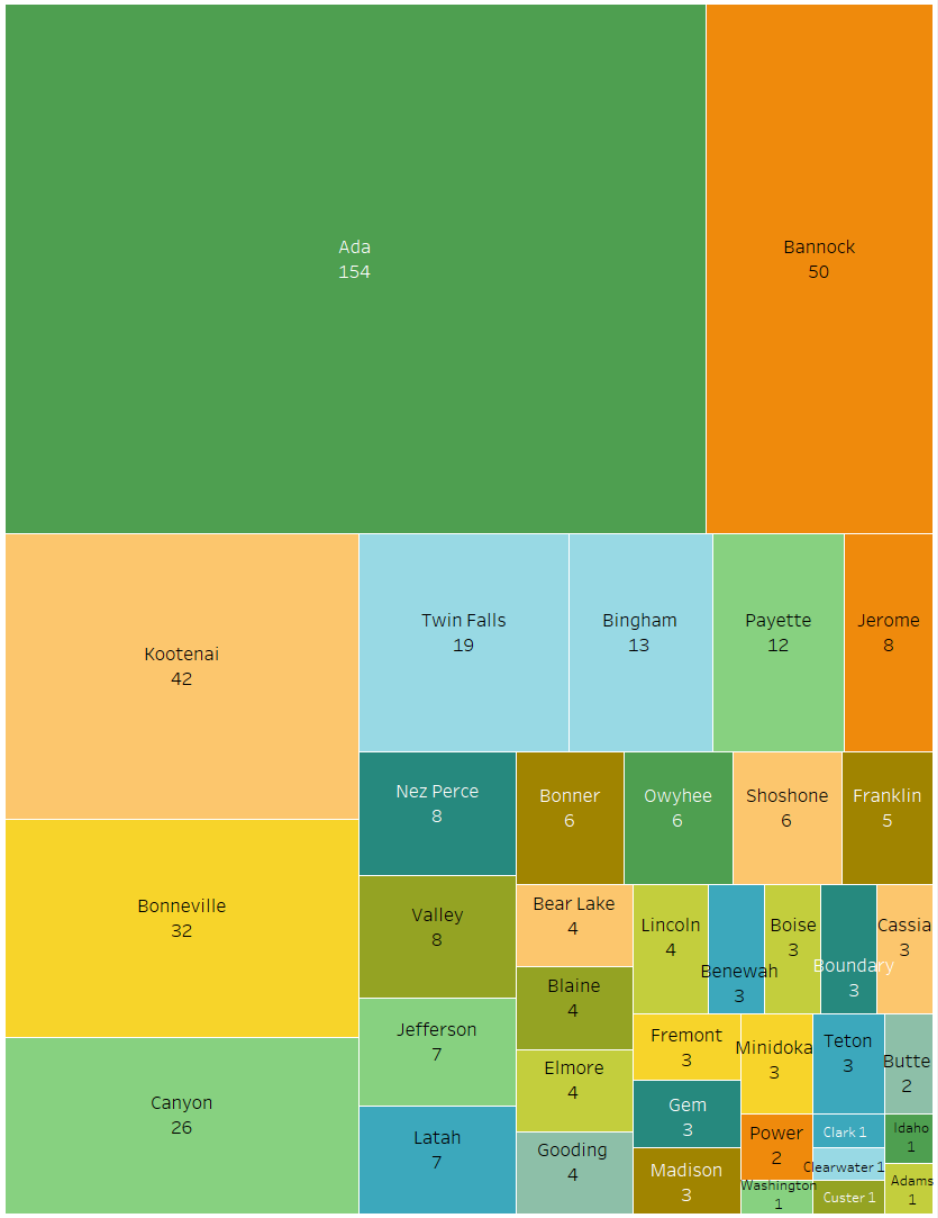
- From 2012-2016 there were 1,140 drug-induced deaths among Idaho residents.
    - Of the 1,140 deaths, 752 death certificates (66%) specified one or more drugs, while 388 records did not (34%).
    - Of the 752 drug-induced deaths in which the death certificate specified the type of drug or drugs, 466 (62%) specified one or more Opioid drug(s), while 286 (38%) did not.
        - Opioids include Opium, Heroin, natural and semisynthetic such as Codeine and Morphine, methadone, synthetic opioids other than methadone, and other and unspecified narcotics (i.e. the death certificate only reports “opioid”).

- Ada county had significantly more drug-overdose deaths with opioid drug(s) specified on the death certificate than any other Idaho county (154 deaths).
    - Of note, Ada county is Idaho’s most populous county and home to the capital city of Boise. With a population of over 400,000 persons, it comprises more than a quarter of Idaho’s total population.

Number of Opioid-Involved Overdose Deaths by State and County (2012-2016)

County of Residence[1]	Number of Drug-Induced Deaths[2]	Number of Drug-Induced Deaths with At Least One Drug Specified On Death Certificate[3]	Number of Drug-Overdose Deaths With Opioid Drug(s) Specified On Death Certificate[4]
Ada	289	263	154
Adams	1	1	1
Bannock	104	67	50
Bear Lake	6	4	4
Benewah	8	6	3
Bingham	30	20	13
Blaine	11	9	4
Boise	7	5	3
Bonner	21	13	6
Bonneville	146	59	32
Boundary	10	6	3
Butte	2	2	2
Camas	1	-	-
Canyon	115	41	26
Caribou	1	-	-
Cassia	7	3	3
Clark	1	1	1
Clearwater	3	3	1
Custer	1	1	1
Elmore	13	5	4
Franklin	12	6	5
Fremont	7	3	3
Gem	13	5	3
Gooding	8	5	4
Idaho	7	5	1
Jefferson	8	8	7
Jerome	12	11	8
Kootenai	80	64	42
Latah	18	11	7
Lemhi	9	3	-
Lewis	3	2	-
Lincoln	4	4	4
Madison	6	5	3
Minidoka	15	3	3
Nez Perce	27	15	8
Oneida	1	-	-
Owyhee	9	8	6
Payette	29	22	12
Power	7	7	2
Shoshone	15	9	6
Teton	4	3	3
Twin Falls	58	35	19
Valley	10	8	8
Washington	1	1	1
Total	**1,140**	**752**	**466**

*This graph shows the distribution of the 466 opioid-involved overdose deaths recorded in Idaho from 2012-2016 by county. The size of the box is proportional to the percent of the total state deaths represented by that county.



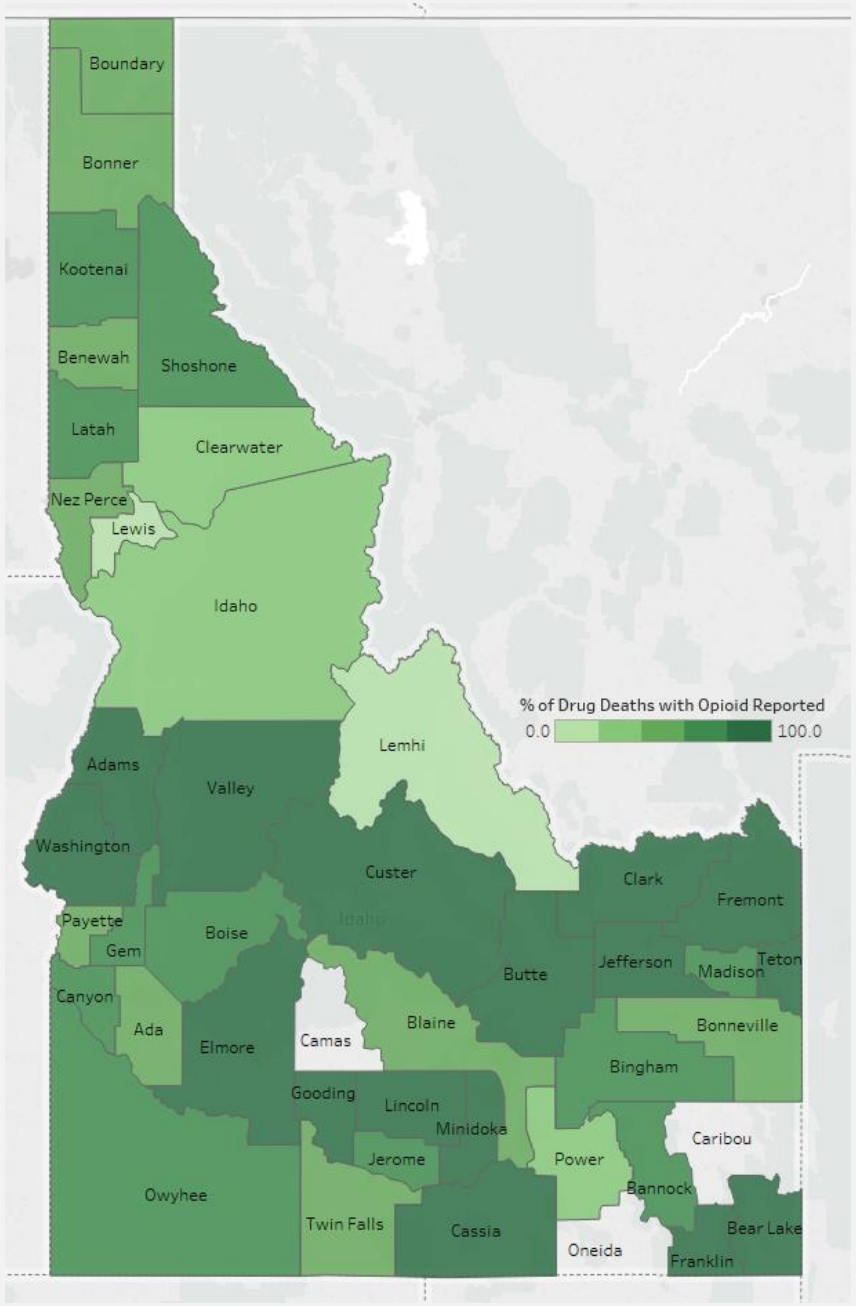
[1]County of residence may or may not be the county death occurred.
[2]Drug-Induced deaths include drug deaths due to natural (chronic drug use), and drug poisoning by accident, suicide, homicide, and undetermined intent of injury.
[3]Decedents may have none, one, or more than one drug specified on the death certificate.
[4]Opioids Include Opium, Heroin, Natural and semisynthetic opioids, Methadone, Synthetic opioids other than methadone, and other and unspecified narcotics (i.e. "opioid" not specified).

Bureau of Vital Records and Health Statistics; Division of Public Health (July 2017)

Percent of Drug-Induced Deaths (Where a Drug Was Specified) That Reported One or More Opioid(s) by State and County (2012-2016)

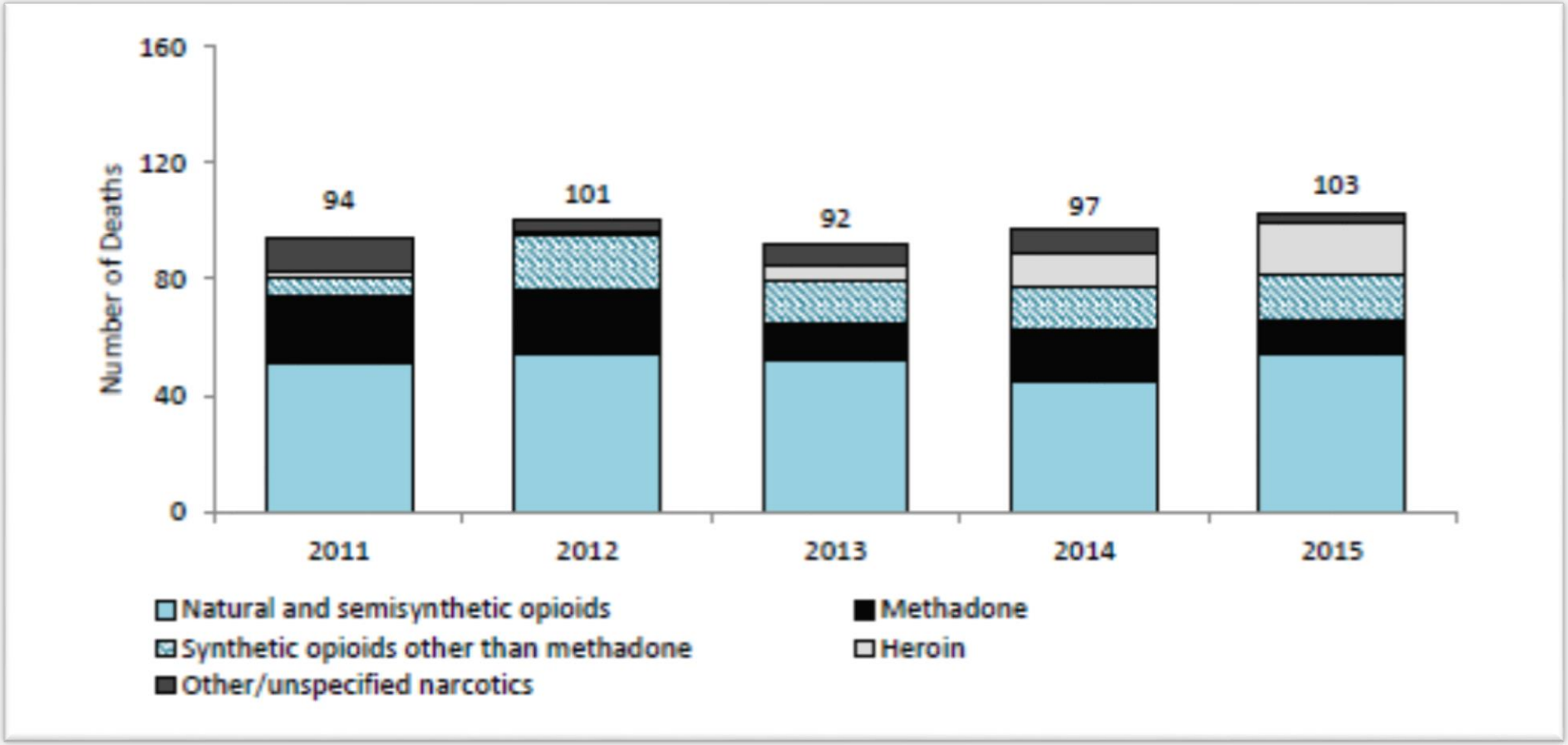
[1]County of residence may or may not be the county death occurred.
[2]Drug-Induced deaths include drug deaths due to natural (chronic drug use), and drug poisoning by accident, suicide, homicide, and undetermined intent of injury.
[3]Decedents may have none, one, or more than one drug specified on the death certificate.
[4]Opioids Include Opium, Heroin, Natural and semisynthetic opioids, Methadone, Synthetic opioids other than methadone, and other and unspecified narcotics (i.e. "opioid" not specified).

Bureau of Vital Records and Health Statistics; Division of Public Health (July 2017)



County of Residence[1]	Number of Drug-Induced Deaths with At Least One Drug Specified On Death Certificate[3]	Number of Drug-Overdose Deaths With Opioid Drug(s) Specified On Death Certificate[4]	Percent of Drug-Induced Deaths with Drug Specified That Reported One or More Opioid(s)
Ada	263	154	58.6%
Adams	1	1	100.0%
Bannock	67	50	74.6%
Bear Lake	4	4	100.0%
Benewah	6	3	50.0%
Bingham	20	13	65.0%
Blaine	9	4	44.4%
Boise	5	3	60.0%
Bonner	13	6	46.2%
Bonneville	59	32	54.2%
Boundary	6	3	50.0%
Butte	2	2	100.0%
Camas	-	-	NA
Canyon	41	26	63.4%
Caribou	-	-	NA
Cassia	3	3	100.0%
Clark	1	1	100.0%
Clearwater	3	1	33.3%
Custer	1	1	100.0%
Elmore	5	4	80.0%
Franklin	6	5	83.3%
Fremont	3	3	100.0%
Gem	5	3	60.0%
Gooding	5	4	80.0%
Idaho	5	1	20.0%
Jefferson	8	7	87.5%
Jerome	11	8	72.7%
Kootenai	64	42	65.6%
Latah	11	7	63.6%
Lemhi	3	-	0.0%
Lewis	2	-	0.0%
Lincoln	4	4	100.0%
Madison	5	3	60.0%
Minidoka	3	3	100.0%
Nez Perce	15	8	53.3%
Oneida	-	-	NA
Owyhee	8	6	75.0%
Payette	22	12	54.5%
Power	7	2	28.6%
Shoshone	9	6	66.7%
Teton	3	3	100.0%
Twin Falls	35	19	54.3%
Valley	8	8	100.0%
Washington	1	1	100.0%
Total	**752**	**466**	**62.0%**

Number of Drug-Induced Deaths Reported on the Death Certificate by Opioid Category (2011-2015)



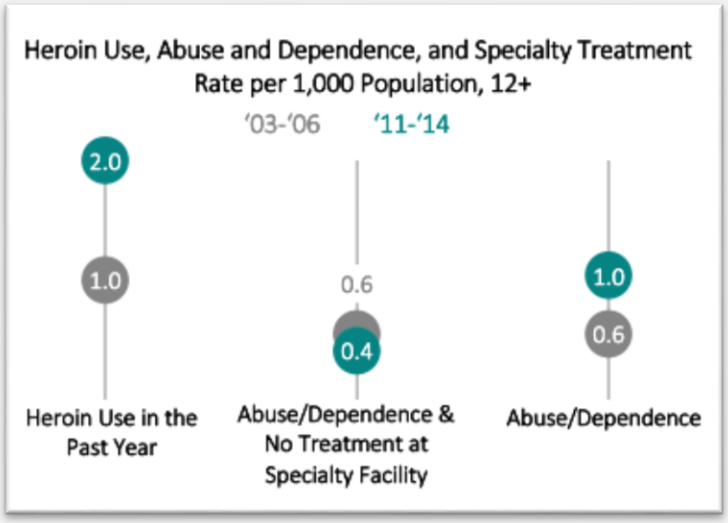
- Since 2011, the proportion of opioid-related drug-induced deaths attributed to heroin has increased significantly, while overall the number of deaths per year has remained fairly consistent year-to-year.
- Due to the lack of standard and reliable reporting of drugs involved in drug-induced deaths across the state, it is unclear whether the increase in heroin-related deaths is a true trend, or whether it is related to changes in reporting.

Bureau of Vital Records and Health Statistics; Division of Public Health (July 2017)

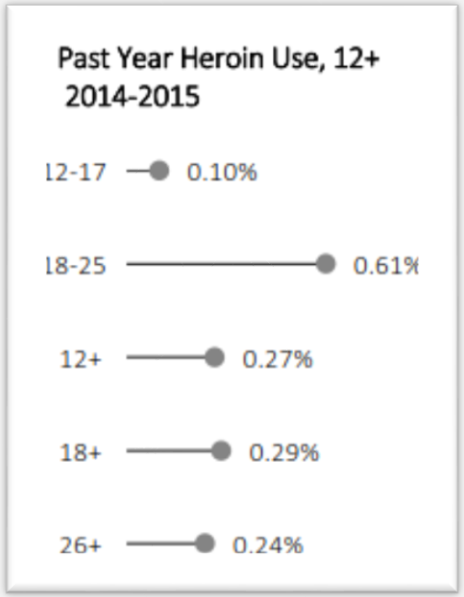
III. Estimating the Current Treatment Need in Idaho

Heroin Use, Misuse, Dependence, and Specialty Treatment; based on the National Survey on Drug Use and Health (NSDUH, 2003-2014)

Between 2003 and 2014, past year heroin use in Idaho increased from 1 to 2 per 1,000 population.



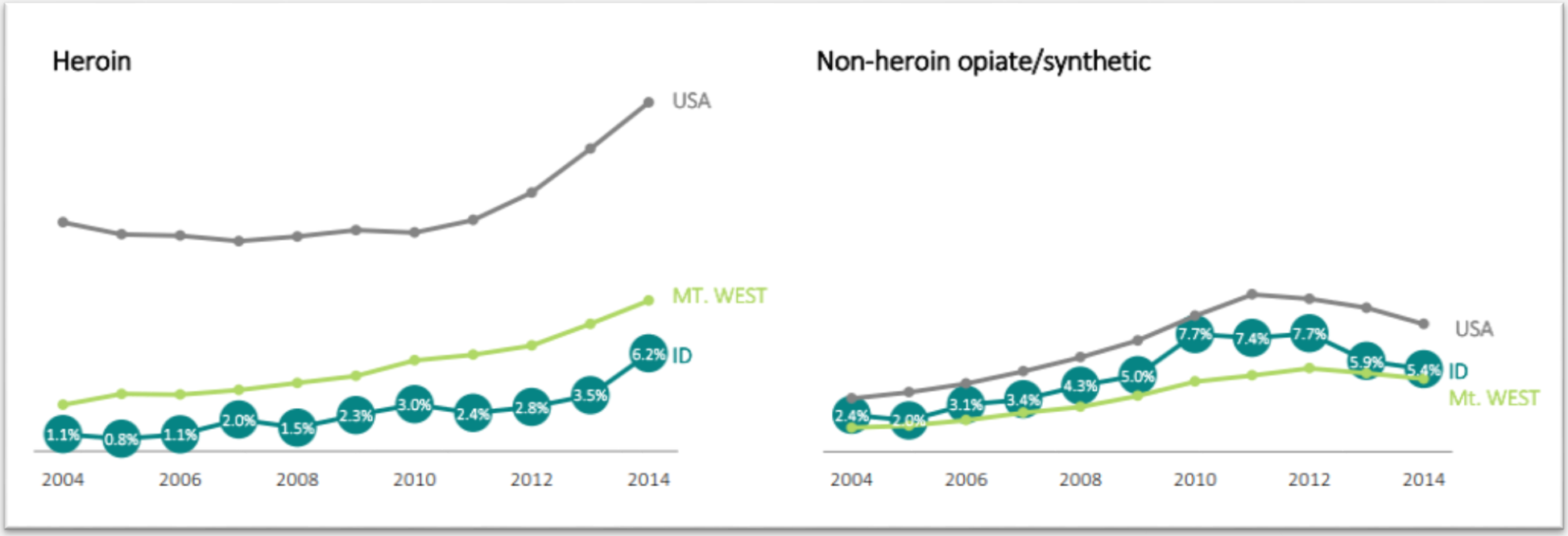
- In 2014/2015, past year heroin use was most common among Idahoans 18 to 25 and least common among Idahoans 12 to 17.
- Idahoans aged 18 to 25 were 2.5 times more likely to use heroin in the past year than Idahoans over 26.
- Past year heroin misuse or dependence in Idaho has increased by 67% between 2003 and 2014.
- The rate of Idahoans who misused heroin or were dependent on heroin and did not received treatment at a specialty facility decreased by 33% between 2003 and 2014.



SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2003-2005, 2006-2008 (Revised 3/12) and 2009-2010 (Revised 3/12), 2011-2014, 2014-2015; Idaho Office of Drug Policy, Opioid Needs Assessment

Opioid Substance Abuse Treatment; based on the Treatment Episode Data Set (TEDS, 2004-2014)[1]

Between ’04 and ’14, the proportion of primary treatment admissions for heroin in Idaho increased more than 5-fold.



- The proportion of primary treatment admissions for heroin in Idaho is below both the rate for the nation and the Mountain West, which includes Idaho, Montana, Wyoming, Nevada, Utah, Colorado, Arizona, New Mexico, and Alaska.
- In 2014, the proportion of primary treatment admissions for heroin in the United States was more than three times higher than in Idaho.
- In 2014, the proportion of primary treatment admissions for heroin in the Mountain West was 54% higher than in Idaho.
- Between ’04 and ’14, the proportion of primary treatment admissions for non-heroin opiate/synthetic treatment admissions in Idaho more than doubled.
- The proportion of primary treatment admissions for non-heroin opiates/synthetics in Idaho is below the rate for the nation but above the Mountain West.
- In 2014, the proportion of primary treatment admissions for non-heroin opiates/synthetics in the United States was 54% higher than in Idaho.
- In 2014, the proportion of primary treatment admissions for non-heroin opiates/synthetics in the Mountain West was 12% lower than in Idaho.
- In Idaho in 2014, the proportion of primary treatment admissions for heroin was higher than for non-heroin opiates/synthetics.

Center for Behavioral Health Statistics and Quality, Substance Abuse Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 02.01.16; Idaho Office of Drug Policy, Opioid Needs Assessment

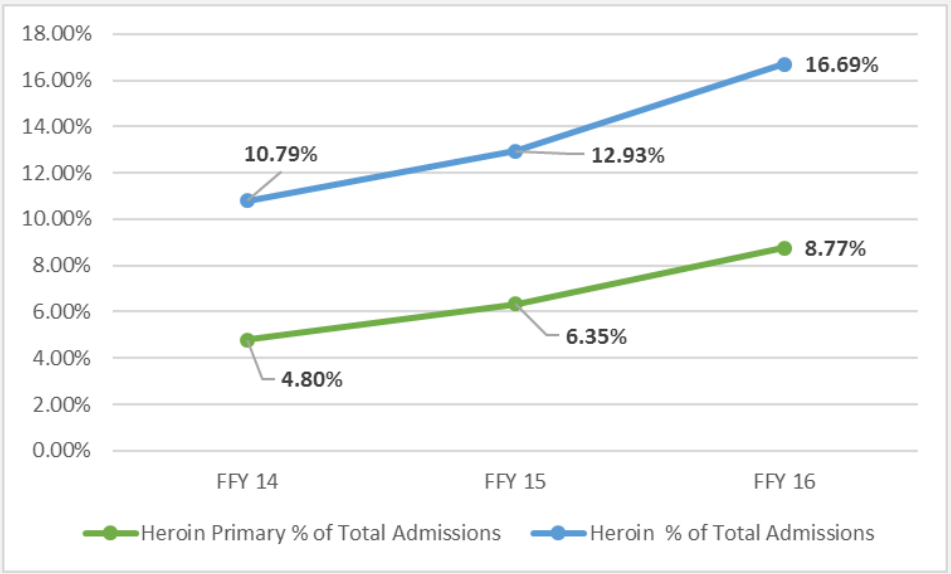
[1]Data from the TEDS are based on admission records for individuals entering publicly funded Substance Use Disorder Treatment. This data includes individuals that received funding for Substance Use Disorder Treatment through Idaho Department of Health and Welfare, Idaho Department of Correction, Idaho Department of Juvenile Correction, and Idaho Supreme Court.

Admissions Records for Individuals Entering Idaho's Publicly Funded Substance Use Disorder Treatment Network for Treatment of Heroin (FFY 2014-2016)

	FFY 14	FFY 15	14-15 Change	FFY 15	FFY 16	15-16 Change
Total Admissions	8,279	9,433	+ 1,154	9,433	8,916	- 517
Heroin as Primary	397	599	+ 202	599	782	+ 183
% of Total Admissions	4.80%	6.35%	+ 1.55%	6.35%	8.77%	+ 2.42%
Heroin as Secondary	358	458	+ 100	458	488	+ 30
% of Total Admissions	4.32%	4.86%	+ 0.54%	4.86%	5.47%	+ 0.61%
Heroin as Tertiary	138	163	+ 25	163	218	+ 55
% of Total Admissions	1.67%	1.72%	+ 0.05%	1.72%	2.45%	+ 0.73%
Heroin Total	893	1,220	+ 327	1,220	1,488	+ 268
% of Total Admissions	10.79%	12.93%	+ 2.14%	12.93%	16.69%	+ 3.76%

Overall, heroin was associated with 16.69% of admissions (1,488 of 8,916) to Idaho's publicly funded Substance Use Disorder Treatment Network in Fiscal Year 2016.

- This represented a 3.76% increase from Fiscal Year 2015 [1,220 admissions (12.93%)] and a 5.90% increase from Fiscal Year 2014 [893 admissions (10.79%)].
- The percentage of total admissions in which heroin was listed as the primary reason for admission likewise increased 2.42% from 2015 to 2016 [from 599 admissions (6.35%) to 782 admissions (8.77%)] and 3.97% from 2014 to 2016 [from 397 admissions (4.80%) to 782 admissions (8.77%)].
- While total admissions decreased by 517 from 2015-2016, total heroin admissions increased by 268.

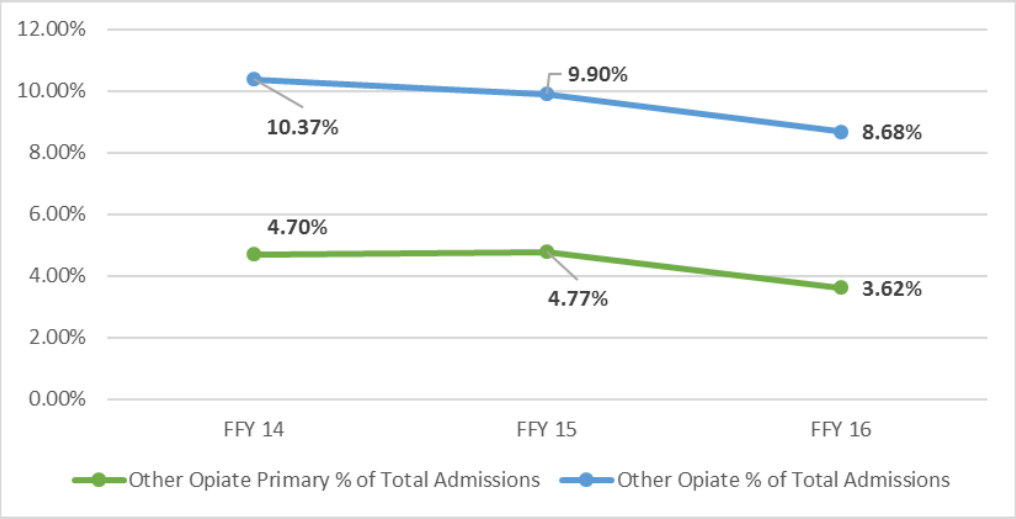


*This data is based on Admissions records for individuals entering publicly funded Substance Use Disorder Treatment Network from October 1, 2013 – September 30, 2014, compared to October 1, 2014 – September 30, 2015 and October 1, 2015 – September 30, 2016. This data includes individuals that received funding for Substance Use Disorder Treatment through Idaho Department of Health and Welfare, Idaho Department of Correction, Idaho Department of Juvenile Corrections, and Idaho Supreme Court. Due to limited funding, these entities are not able to provide treatment for all individuals meeting financial criteria; rather, funding eligibility is also based on additional criteria including, but not limited to: Intravenous Drug Use, Pregnant and Parenting Women, Criminal Justice Involvement, individuals with mental health needs, etc. This data does not include individuals who received treatment funded by Medicaid.

Admissions Records for Individuals Entering Idaho's Publicly Funded Substance Use Disorder Treatment Network for Treatment of Opiates other than Heroin (FFY 2014-2016)

	FFY 14	FFY 15	14-15 Change	FFY 15	FFY 16	15-16 Change
Total Admissions	8,279	9,433	+ 1,154	9,433	8,916	- 517
Other Opiates as Primary	389	450	+ 61	450	323	- 127
% of Total Admissions	4.70%	4.77%	+ 0.07%	4.77%	3.62%	- 1.15%
Other Opiates as Secondary	311	314	+ 3	314	288	- 26
% of Total Admissions	3.75%	3.33%	- 0.42%	3.33%	3.23%	- 0.10%
Other Opiates as Tertiary	159	170	+ 11	170	163	- 7
% of Total Admissions	1.92%	1.80%	- 0.12%	1.80%	1.83%	+ 0.03%
Other Opiates Total	859	934	+ 75	934	774	- 160
% of Total Admissions	10.37%	9.90%	- 0.47%	9.90%	8.68%	- 1.22%

Overall, opiates other than heroin were associated with 8.68% of admissions (774 of 8,916) to Idaho's publicly funded Substance Use Disorder Treatment Network in Fiscal Year 2016.

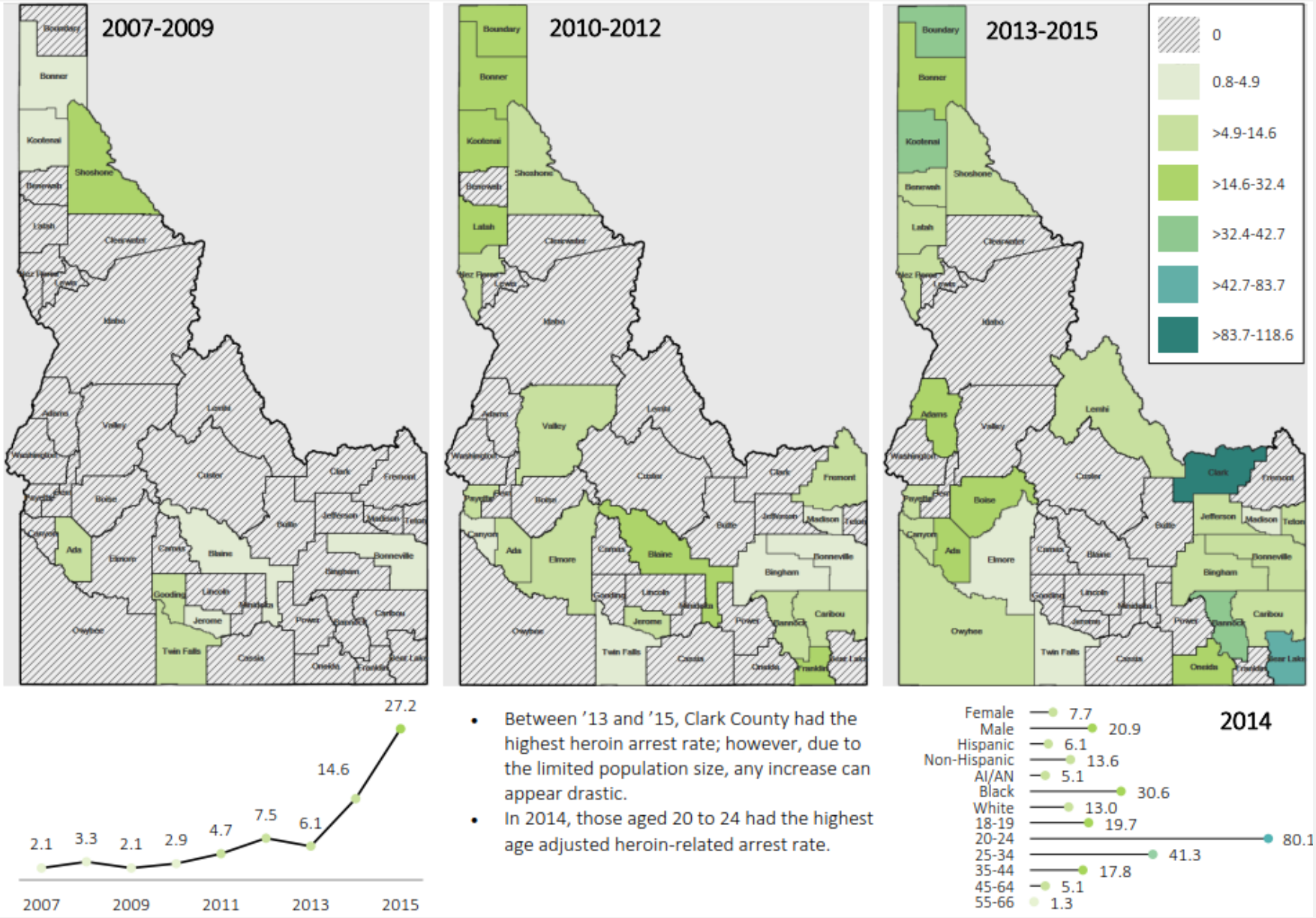


- This represented a 1.22% decrease from Fiscal Year 2015 [934 admissions (9.90%)] and a 1.69% decrease from Fiscal Year 2014 [859 admissions (10.37%)].
- The percentage of total admissions in which opiates other than heroin were listed as the primary reason for admission likewise decreased 1.15% between 2015 and 2016 [from 450 admissions (4.77%) to 323 admissions (3.62%)] and decreased 1.08% from 2014 to 2016 [from 389 admissions (4.70%) to 323 admissions (3.62%)].
- However, there was a small uptick in the percentage of total admissions in which opiates other than heroin were listed as the primary reason for admission between 2014 and 2015 [from 389 admissions (4.70%) to 450 admissions (4.77%)]

*This data is based on Admissions records for individuals entering publicly funded Substance Use Disorder Treatment Network from October 1, 2013 – September 30, 2014, compared to October 1, 2014 – September 30, 2015 and October 1, 2015 – September 30, 2016. This data includes individuals that received funding for Substance Use Disorder Treatment through Idaho Department of Health and Welfare, Idaho Department of Correction, Idaho Department of Juvenile Corrections, and Idaho Supreme Court. Due to limited funding, these entities are not able to provide treatment for all individuals meeting financial criteria; rather, funding eligibility is also based on additional criteria including, but not limited to: Intravenous Drug Use, Pregnant and Parenting Women, Criminal Justice Involvement, individuals with mental health needs, etc. This data does not include individuals who received treatment funded by Medicaid.

Heroin-Related Arrest Rate per 100,000 Population (2007-2015)

Between ’07 and ’15, the heroin arrest rate has increased 13-fold.



Idaho Statistical Analysis Center, Idaho State Police, National Incidence-Based Reporting System, January 2017; Idaho Office of Drug Policy, Opioid Needs Assessment

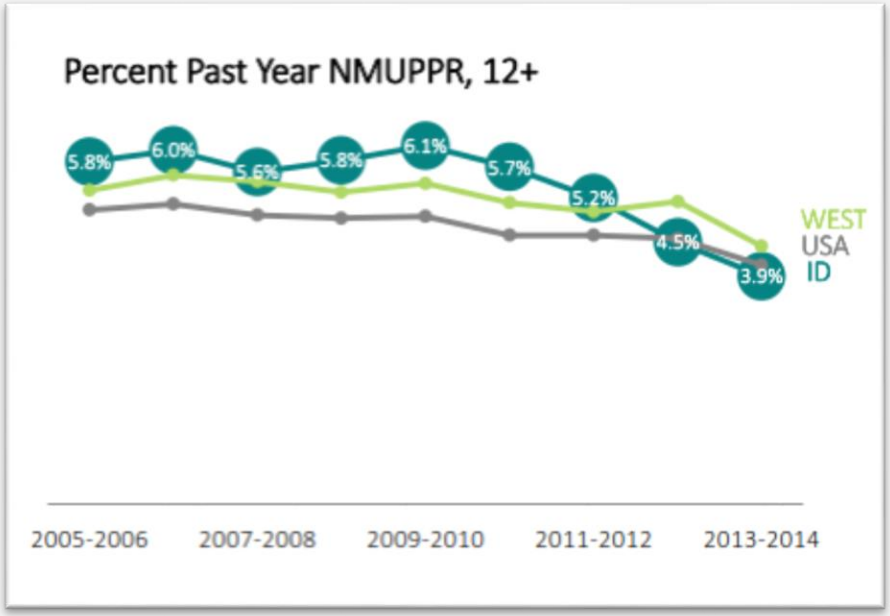
i. Unique Needs: Highlights Regarding Select Demographic Groups and Special Populations in Idaho

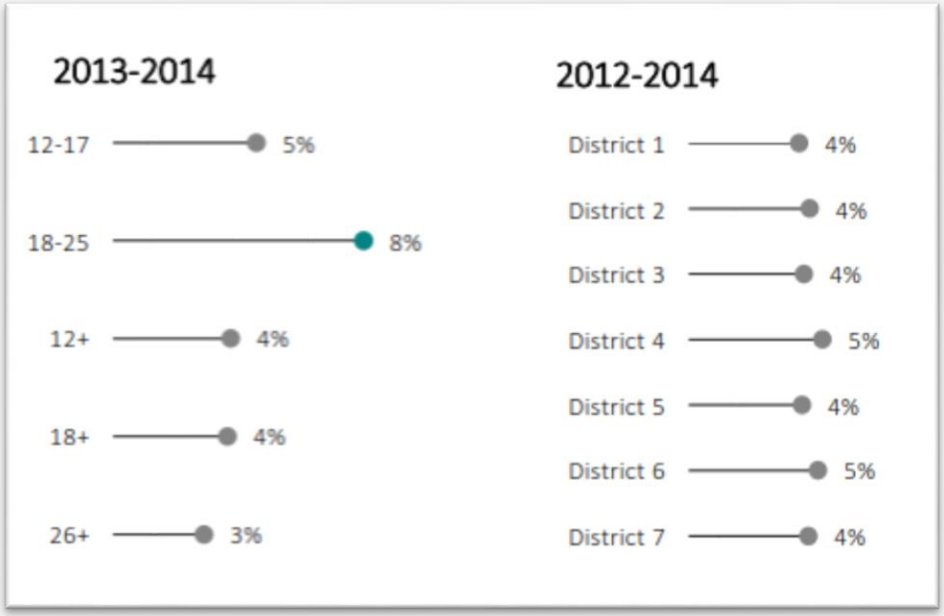
a. Adolescents and Young Adults: High School Students and Individuals Age 18 to 25

According to the National Survey on Drug Use and Health, in 2013-2014, past year nonmedical use of prescription pain relievers was significantly higher among Idahoans aged 18 to 25 when compared to other age groups in Idaho. Idahoans aged 18 to 25, especially those who do not choose to attend a university, are difficult to reach with prevention strategies.

Percent Past Year Nonmedical Use of Prescription Pain Relievers Among Individuals 12 and Older; based on the NSDUH (2005-2014)

Between '05 and '14, the percentage of Idahoans reporting past year nonmedical use of prescription pain relievers (NMUPPR) decreased by 33%.





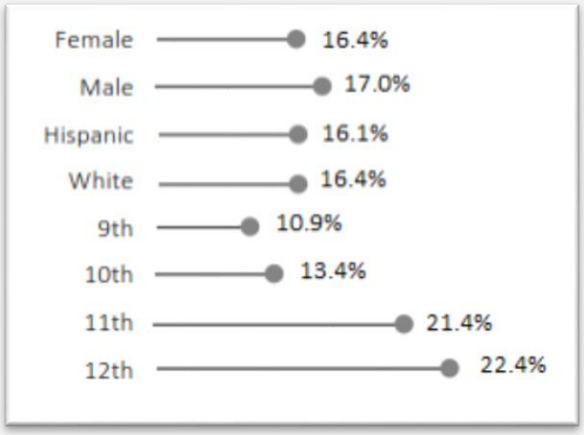
- In 2012, the percentage of Idahoans reporting past year NMUPPR dipped below the national average and the average for the West, which includes Washington, Idaho, Montana, Oregon, Wyoming, California, Nevada, Utah, Colorado, Arizona, New Mexico, Alaska, and Hawaii.
- NMUPPR peaked in '09-'10 in Idaho but decreased by 36% in '13-'14.
- NMUPPR peaked in '06-'07 in the West but decreased by 21% in '13-'14.
- NMUPPR peaked in '06-'07 in the United States but decreased by 20% in '13-'14.
- In 2013-2014, NMUPPR was 13% higher in the West than in Idaho.
- In 2013-2014, NMUPPR was 4% higher in the United States than in Idaho.

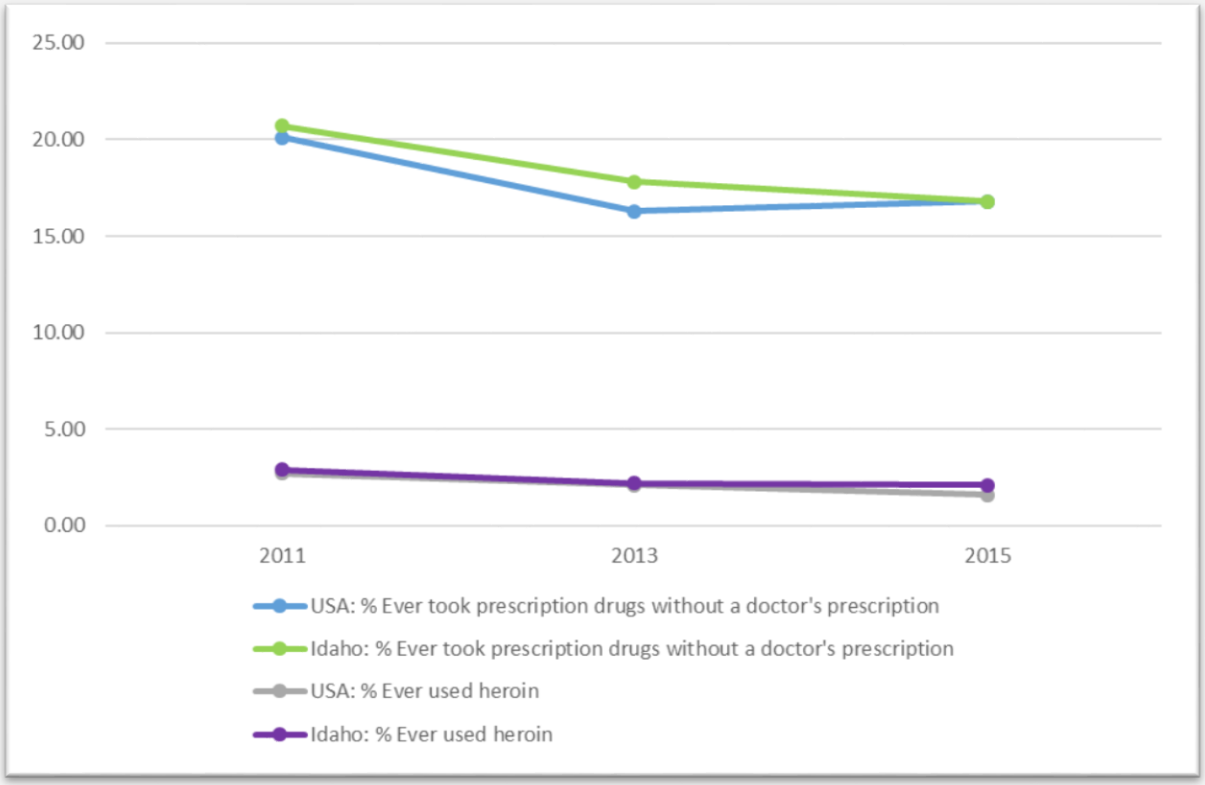
- Idahoans 18 to 25 were most likely to report past year NMUPPR among all age groups.
- There was no difference among Public Health Districts in the percentage of Idahoans reporting NMUPPR in '12-'14.

SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2005-2014, Idaho Office of Drug Policy, Opioid Needs Assessment

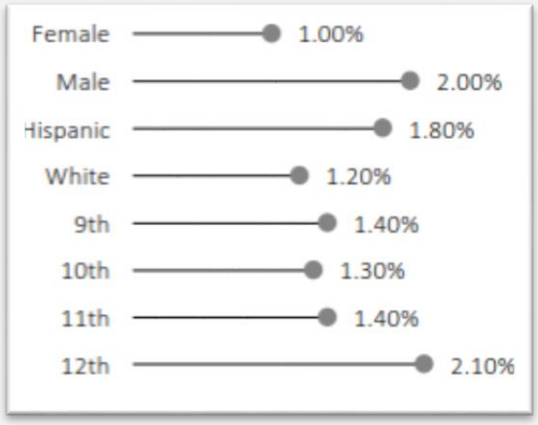
Lifetime Prescription Drug Misuse and Heroin Use Grades 9-12; based on the High School Youth Risk Behavior Survey (YRBS, 2015)

Lifetime Prescription Drug Misuse, Grades 9-12 (2015)





- Idaho has remained slightly below the national average in lifetime use of prescription drugs without a doctor's prescription, though the difference is not significant.
- In 2015, 16.8% of Idaho high school students reported having ever used prescription drugs without a doctor's prescription.
- 11th and 12th grade students were significantly more likely to have misused prescription drugs than 9th and 10th grade students



Lifetime Heroin Use, Grades 9-12 (2015)

- Idaho has also remained slightly (but not significantly) below the national average in lifetime heroin use among high school students.
- In 2015, 1.6% of Idaho high school students reported having ever used heroin in their lifetimes.
- There were no statistically significant differences across demographic groups.

Centers for Disease Control and Prevention, Adolescent and School Health, Youth Risk Behavior Surveillance System (YRBSS), 2015

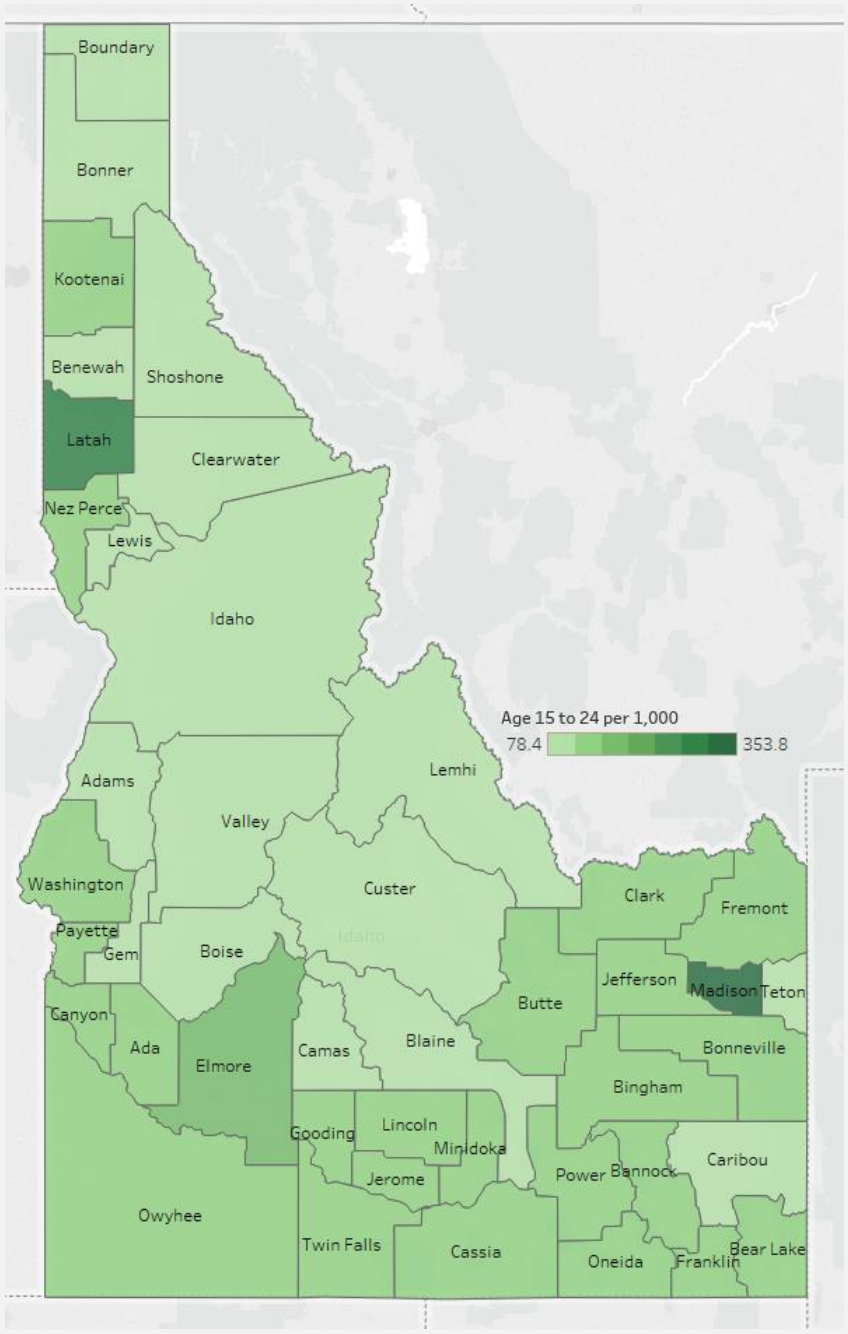
Adolescents and Young Adults in Idaho

Counties with significant populations of young Idahoans represent areas where support could potentially be particularly beneficial, based on data seen above (from the National Survey on Drug Use and Health, the High School Youth Risk Behavior Survey, and Idaho heroin arrests).

There are 226,213 adolescent and young adult Idahoans age 15-24 years old, which is equal to approximately 14% of Idaho's total population. On average, there are 134 individuals age 15-24 per 1,000 persons in the state.

- Ada county, home to the city of Boise, has the largest gross number of adolescents and young adults (417,501).
- Other counties with large populations age 15-24 include Bonneville, Canyon, and Kootenai.
- However, Madison county has the highest rate of adolescents and young adults per 1,000 persons (353.8).
- A large proportion of Latah county's population is also comprised of individuals age 15-24 (287.8 per 1,000).

United States Census Bureau, American FactFinder, 2015

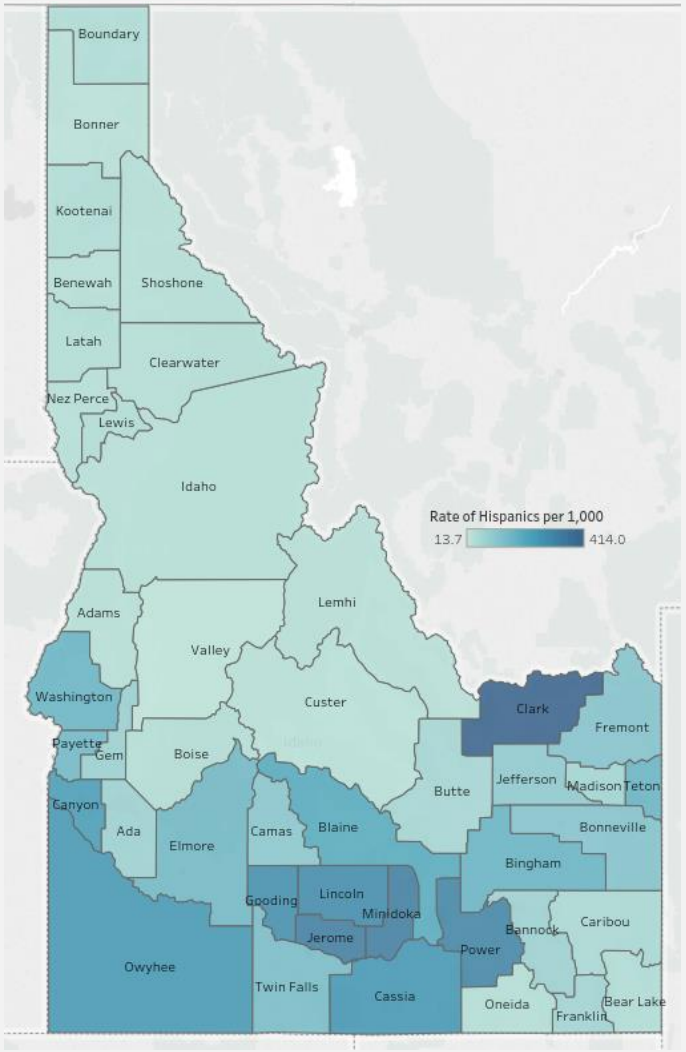


County	Total population	15 to 24 years	% (of Total Population)	Rate per 1,000
Ada	417,501	54,378	13.0%	130.2
Adams	3,880	388	10.0%	100.0
Bannock	83,604	12,769	15.3%	152.7
Bear Lake	5,939	703	11.8%	118.4
Benewah	9,088	1,029	11.3%	113.2
Bingham	45,407	6,108	13.5%	134.5
Blaine	21,309	2,126	10.0%	99.8
Boise	6,885	666	9.7%	96.7
Bonner	41,066	4,061	9.9%	98.9
Bonneville	107,788	14,013	13.0%	130.0
Boundary	10,961	1,221	11.1%	111.4
Butte	2,653	353	13.3%	133.1
Camas	1,052	105	10.0%	99.8
Canyon	198,921	28,578	14.4%	143.7
Caribou	6,808	767	11.3%	112.7
Cassia	23,369	3,242	13.9%	138.7
Clark	901	138	15.3%	153.2
Clearwater	8,560	878	10.3%	102.6
Custer	4,234	332	7.8%	78.4
Elmore	26,175	4,561	17.4%	174.3
Franklin	12,914	1,763	13.7%	136.5
Fremont	12,945	1,735	13.4%	134.0
Gem	16,731	1,849	11.1%	110.5
Gooding	15,233	2,088	13.7%	137.1
Idaho	16,312	1,696	10.4%	104.0
Jefferson	26,792	3,658	13.7%	136.5
Jerome	22,653	3,066	13.5%	135.3
Kootenai	145,046	18,315	12.6%	126.3
Latah	38,339	11,033	28.8%	287.8
Lemhi	7,790	713	9.2%	91.5
Lewis	3,812	389	10.2%	102.0
Lincoln	5,260	725	13.8%	137.8
Madison	37,916	13,413	35.4%	353.8
Minidoka	20,279	2,797	13.8%	137.9
Nez Perce	39,779	5,209	13.1%	130.9
Oneida	4,245	569	13.4%	134.0
Owyhee	11,364	1,524	13.4%	134.1
Payette	22,700	2,883	12.7%	127.0
Power	7,731	1,019	13.2%	131.8
Shoshone	12,571	1,376	10.9%	109.5
Teton	10,285	1,099	10.7%	106.9
Twin Falls	80,004	10,705	13.4%	133.8
Valley	9,720	979	10.1%	100.7
Washington	10,025	1,194	11.9%	119.1
TOTAL	**1,616,547**	**226,213**	**14.0%**	**134.3**

b. Hispanic/Latino Population

County	Total Population	Hispanic or Latino (of any race)	% (of Total Population)	Rate per 1,000
Ada	417,501	31,830	7.6%	76.2
Adams	3,880	120	3.1%	30.9
Bannock	83,604	6,442	7.7%	77.1
Bear Lake	5,939	245	4.1%	41.3
Benewah	9,088	291	3.2%	32.0
Bingham	45,407	8,034	17.7%	176.9
Blaine	21,309	4,362	20.5%	204.7
Boise	6,885	245	3.6%	35.6
Bonner	41,066	1,102	2.7%	26.8
Bonneville	107,788	13,316	12.4%	123.5
Boundary	10,961	457	4.2%	41.7
Butte	2,653	162	6.1%	61.1
Camas	1,052	119	11.3%	113.1
Canyon	198,921	48,640	24.5%	244.5
Caribou	6,808	363	5.3%	53.3
Cassia	23,369	6,129	26.2%	262.3
Clark	901	373	41.4%	414.0
Clearwater	8,560	310	3.6%	36.2
Custer	4,234	113	2.7%	26.7
Elmore	26,175	4,209	16.1%	160.8
Franklin	12,914	883	6.8%	68.4
Fremont	12,945	1,598	12.3%	123.4
Gem	16,731	1,341	8.0%	80.2
Gooding	15,233	4,381	28.8%	287.6
Idaho	16,312	506	3.1%	31.0
Jefferson	26,792	2,771	10.3%	103.4
Jerome	22,653	7,558	33.4%	333.6
Kootenai	145,046	6,061	4.2%	41.8
Latah	38,339	1,520	4.0%	39.6
Lemhi	7,790	226	2.9%	29.0
Lewis	3,812	155	4.1%	40.7
Lincoln	5,260	1,557	29.6%	296.0
Madison	37,916	2,515	6.6%	66.3
Minidoka	20,279	6,775	33.4%	334.1
Nez Perce	39,779	1,371	3.4%	34.5
Oneida	4,245	149	3.5%	35.1
Owyhee	11,364	2,955	26.0%	260.0
Payette	22,700	3,695	16.3%	162.8
Power	7,731	2,435	31.5%	315.0
Shoshone	12,571	419	3.3%	33.3
Teton	10,285	1,792	17.4%	174.2
Twin Falls	80,004	11,914	14.9%	148.9
Valley	9,720	133	1.4%	13.7
Washington	10,025	1,742	17.4%	173.8
Total	**1,616,547**	**191,314**	**11.8%**	**124.2**

According to the Idaho Behavioral Risk Factor Surveillance System in 2014, a significantly higher percentage of Hispanics reported that there was no or slight risk in using prescription drugs not prescribed by a licensed medical provider. Although higher past 30-day use of prescription drugs was not seen among this demographic, prevention strategies should be culturally competent and tailored to Idaho's Hispanic population. Areas of Idaho comprised of particularly high concentrations of Hispanic persons are identified below.



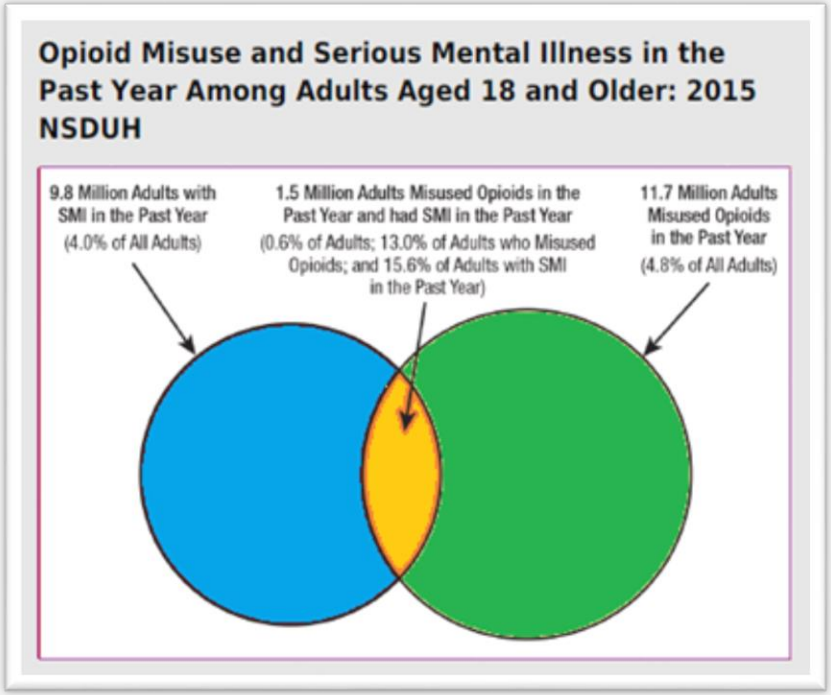
There are 191,314 persons of Hispanic or Latino ethnicity in Idaho, which is equal to approximately 12% of Idaho's total population. On average, there are 124 Hispanic individuals per 1,000 persons in the state.

- Canyon county has the largest gross number of Hispanics (48,640).
- However, Clark county has the highest rate of individuals reporting Hispanic or Latino ethnicity per 1,000 persons (414.0).
- A large proportion of Jerome, Minidoka, and Power counties populations are also comprised of Hispanic persons.
- Clark and Power counties are Frontier counties, while Jerome and Minidoka counties are rural.

United States Census Bureau, American FactFinder, 2015

c. Mental Illness

Estimated Past Year Opioid Misuse and Serious Mental Illness (SMI) among Adults in Idaho, by Age Group; based on the NSDUH (2014-2015)



Adults with serious mental illness appear to be at a greater risk of misusing opioids than adults in the general population. SAMHSA estimates that while only 4.8% of all adults misused opioids in the past year, 15.6% of all adults with SMI misused opioids. Nationally, these rates correspond to 11.7 million adults that misused opioids and 1.5 million adults that misused opioids and had SMI.

- Based on these statistics and the 2014-15 National Survey on Drug Use and Health, there are over 8,000 estimated adults in Idaho with both serious mental illness and opioid misuse in the past year. This corresponds to 0.73% of all adults in Idaho, higher than the percentage seen nationally (0.6%).
- SMI and opioid misuse appears to be more prevalent in young adult Idahoans than in the general population of adults age 18 and older. Based on the 2014-2015 NSDUH, an estimated 0.89% of all adults age 18-25 (1,560 persons) experienced both SMI and opioid misuse in the past year, as opposed to 0.73% (8,580) of the general adult population.

Age	Idaho Adults with SMI	Estimate of Idaho Adults with SMI and Opioid Misuse	Total Population of Idaho Adults	% of Idaho Adults with SMI and Opioid Misuse
18+	55,000	8,580	1,175,000	0.73%
18-25	10,000	1,560	175,000	0.89%
26+	45,000	7,020	1,000,000	0.70%

SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2014-2015; SAMHSA, The CBHSQ Report, 1.5 Million Adults Have Serious Mental Illness and Misused Opioids in the Past Year, 2017

IV. The Current Availability of Medication-Assisted Treatment in Idaho

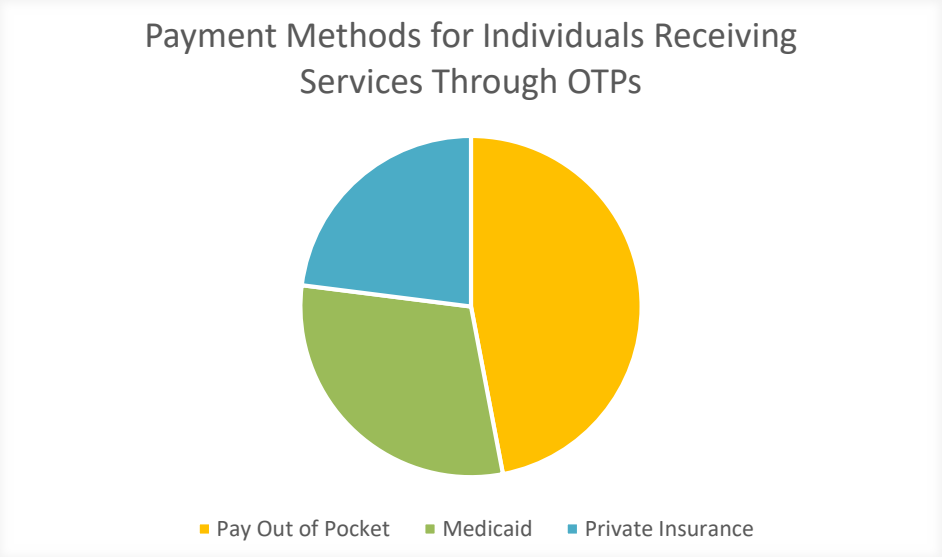
- Idaho has 2 Opioid Treatment Providers (OTP's) with a total of 3 locations which are all within Ada county.
  - Currently, one of the two agencies reports serving 541 patients with a total capacity of 675.
  - The second agency is serving 530 clients with a capacity of 800 between its 2 locations.

- In addition, Idaho has approximately 90 DATA 2000 waivered physicians.
  - We are currently in the process of determining which Office-based Opioid Treatments (OBOT's) and certified prescribers are prescribing up to their current limits and which ones are eligible to increase their limits and who has or has not and why.
  - We do not currently have a system in place to quickly gather that information due to MAT not historically being publicly funded in Idaho.

V. Current Programmatic Capacity in Idaho

In Idaho, there are only three Opioid Treatment Providers (OTPs) which provide methadone as a Medication Assisted Treatment.

- Individuals receiving services through these agencies must be able to pay out of pocket for medications and counseling or have insurance that will cover them.
- Approximately 47 percent of the OTP clientele pay out of pocket, 30 percent have Medicaid, and 23 percent have private insurance.



Additionally, three Federally Qualified Health Centers (FQHCs) in Idaho are providing Suboxone under limited grant funding through the Health Resources and Services Administration (HRSA) but most of this funding has been exhausted. Those Centers, and the amount of funding they received are: Boundary Regional Community Health Center, Inc ($325,000); Community Health Clinics, Inc ($352,083); Dirne Health Centers ($325,000). With this funding, these three FQHCs agreed to implement Opioid Replacement Treatment Programs (ORTPs) serving a total of 90 Idahoans.

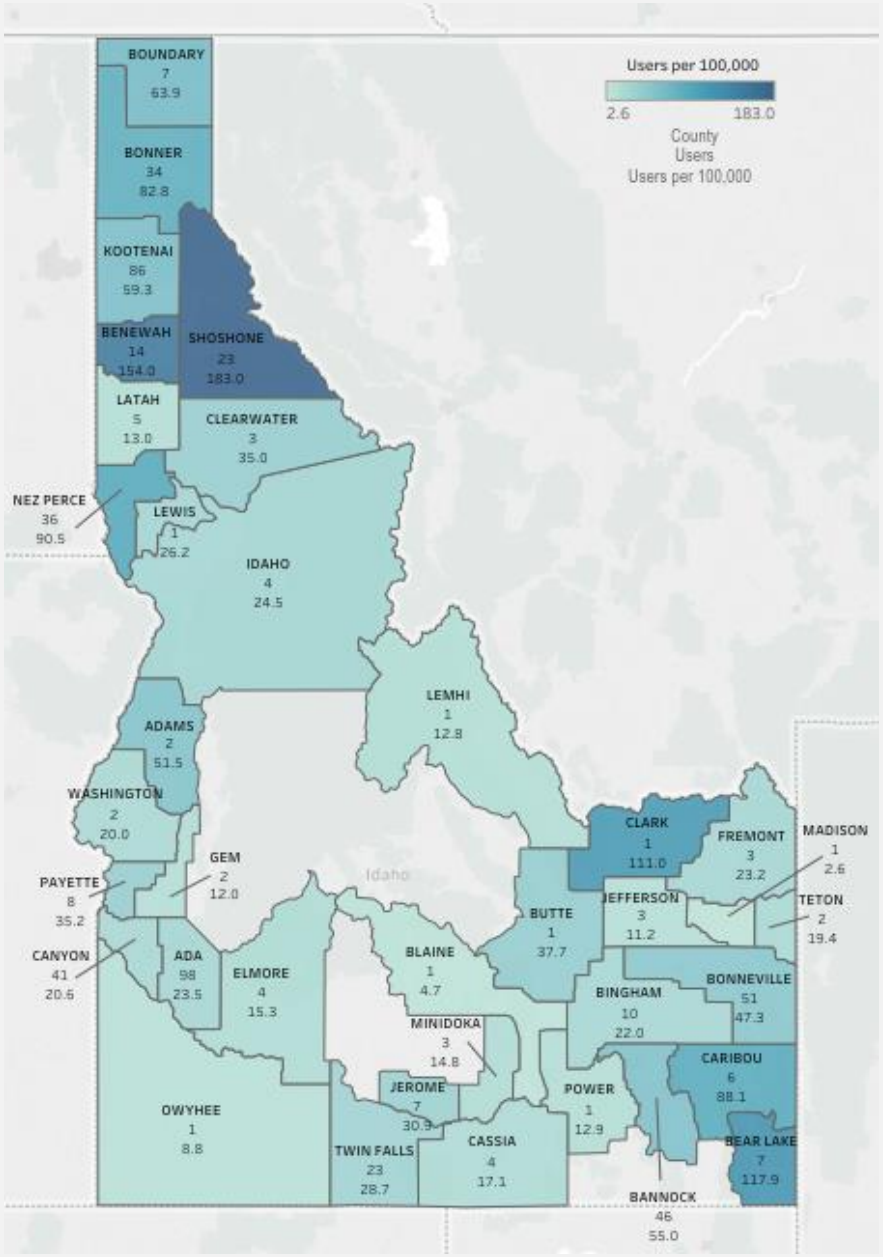
Idaho Medicaid Beneficiaries that Received Suboxone or Subutex in the Past Year by County, and Users per 100,000 Persons Based on US Census County Population Estimates (2016-2017)

There were 542 Idaho Medicaid beneficiaries that received Suboxone or Subutex in the past year (July 2016-July 2017) with an average of 33.5 users of Suboxone or Subutex per 100,000 persons.

- Ada county had the largest number of users (98 users), followed closely by Kootenai county (86 users).
- However, Shoshone county had the highest rate of users per 100,000 persons (183.0 per 100,000)
- The lowest rate of users per 100,000 persons was seen in Madison county (2.6 per 100,000).

Idaho Department of Health and Welfare, Medicaid Pharmacy Program; July 18-2016-July 17, 2017

COUNTY	USERS (N=542)	% (OF ALL USERS)	POPULATION	USERS PER 100,000
Ada	98	18.08%	417,501	23.5
Adams	2	0.37%	3,880	51.5
Bannock	46	8.49%	83,604	55.0
Bear Lake	7	1.29%	5,939	117.9
Benewah	14	2.58%	9,088	154.0
Bingham	10	1.85%	45,407	22.0
Blaine	1	0.18%	21,309	4.7
Bonner	34	6.27%	41,066	82.8
Bonneville	51	9.41%	107,788	47.3
Boundary	7	1.29%	10,961	63.9
Butte	1	0.18%	2,653	37.7
Canyon	41	7.56%	198,921	20.6
Caribou	6	1.11%	6,808	88.1
Cassia	4	0.74%	23,369	17.1
Clark	1	0.18%	901	111.0
Clearwater	3	0.55%	8,560	35.0
Elmore	4	0.74%	26,175	15.3
Fremont	3	0.55%	12,945	23.2
Gem	2	0.37%	16,731	12.0
Idaho	4	0.74%	16,312	24.5
Jefferson	3	0.55%	26,792	11.2
Jerome	7	1.29%	22,653	30.9
Kootenai	86	15.87%	145,046	59.3
Latah	5	0.92%	38,339	13.0
Lemhi	1	0.18%	7,790	12.8
Lewis	1	0.18%	3,812	26.2
Madison	1	0.18%	37,916	2.6
Minidoka	3	0.55%	20,279	14.8
Nez Perce	36	6.64%	39,779	90.5
Owyhee	1	0.18%	11,364	8.8
Payette	8	1.48%	22,700	35.2
Power	1	0.18%	7,731	12.9
Shoshone	23	4.24%	12,571	183.0
Teton	2	0.37%	10,285	19.4
Twin Falls	23	4.24%	80,004	28.7
Washington	2	0.37%	10,025	20.0
Idaho	**542**	**100.00%**	**1,616,547**	**33.5**



VI. Idaho's Prevention System

The current substance use prevention system in Idaho to address the opioid crisis is a collaborative, multi-disciplinary effort aimed at employing evidence-based prevention strategies and public policy initiatives to help Idaho become a state that is free from the devastating economic, health and social effects of substance misuse.

In the past several years, the Office of Drug Policy (ODP) has secured various coordinated funding streams to target opioid misuse including the Substance Abuse Block Grant, the Strategic Prevention Framework State Incentive Grant (SPF SIG), the State Targeted Response to the Opioid Crisis Grant, the Prescription Drug Overdose: Data-Driven Prevention Initiative Grant, and the Idaho Millennium Fund. Key stakeholders receiving funding for these grants have been able to work collaboratively to braid funding streams to maximize prevention and treatment support in Idaho communities.

Through these grant funds, activities conducted include administering evidence-based direct services conducted in schools, juvenile detention centers, and community centers; supporting substance abuse prevention coalitions and law enforcement prescription drug task forces; installing medication drop boxes in both law enforcement agencies and pharmacies; and collaborating with stakeholders.

i. Strengths

Idaho utilizes a variety of evidence-based practices in prevention education to support behavioral health among both youth and adults alike. Further, Idaho's Strategic Prevention Framework State Incentive (SPF SIG) Grant funded coalitions use evidence-based environmental strategies to target communities in drug prevention.

Similarly to communities relying on several partners to implement prevention strategies, the State of Idaho convenes several workgroups that include multi-sector committed partners in prevention. Although ODP and the Department of Health and Welfare (DHW), Divisions of Behavioral Health and Public Health are at the helm of the substance abuse prevention system, various other agencies' policy and activities work in concert to complete the work.

Two workgroups that facilitate improvement of opioid-related issues in the state include the Opioid Misuse and Overdose Workgroup and the State Epidemiological Outcomes Workgroup. The Opioid Misuse and Overdose Workgroup is composed of approximately 60 representatives in a variety of fields including the legislature, executive branch agencies, public health agencies, medical associations, treatment providers, law enforcement agencies, medical boards, coroners, family members, physicians, prosecutors, universities, Medicaid, and others. The mission of the workgroup is "a safe and healthy Idaho, free of opioid use and untreated opioid disorders". The workgroup has drafted a five-year strategic plan and is convening sub-committees to implement the action plans and meet the goals of the plan.

The State Epidemiological Outcomes Workgroup is a surveillance group whose mission is to assist the state through prevention assessment, planning, implementation, and monitoring effects to improve behavioral health among all Idahoans. This group is composed of various individuals employed at state agencies including ODP, DHW, the Idaho Supreme Court, the Idaho Department of Corrections, the Idaho Department of Juvenile Corrections, Idaho State Police, and Career and Technical Education, who have access to behavioral health data. Various reports have been compiled by members of this group to better understand opioid abuse and misuse in Idaho.

Collaboration is fundamental in passing policy initiatives to prevent opioid use and related consequences. Key pieces of state legislation have allowed for increased Naloxone availability to the public and first responders, a more robust prescription drug monitoring program (PMP), and partial prescription fills for patients who opt to limit their dosage of controlled substances.

ii. Areas of Improvement

In addition to Idaho's strengths, there are still areas of improvement. With an ever-changing landscape of drug prevention, continual education to key stakeholders is essential. Regarding opioid misuse, prescribers, patients, and the public should be well informed. In Idaho, prescribers could benefit from additional education regarding evidence-based prescribing guidelines, unintended consequences of inappropriate prescribing practices, effective PMP usage, and holistic or alternative options for treatment that do not include opioid prescriptions.

Patients with limited health autonomy or awareness may not have the tools to make informed decisions regarding their own pain management. Educated patients are more able to make decisions regarding their access to Naloxone, their ability to fill partial prescriptions, the consequences of opioid use, and their prerogative to choose alternative methods besides prescription opioids to reduce pain.

Improving the public's knowledge of opioid-related topics corrects perceptions of the opioid issue and improves the public's ability to influence other effective strategies, including policy change. Specific topic areas that should be addressed in public education are scope of the opioid issue, the reduction of stigma of addiction, and the opportunity for families to access support services.

There is room to improve prescribing practices. There is a large need for reinforcing prescribers who check the PMP; using PMP data strategically; maximizing value of the PMP, which may include the addition of reportable fields such as patient diagnosis; and integrating the PMP and electronic medical records. Considerations to improve prescribing practices are establishing prescriber buy-in, making compliance seamless, limiting the perception of pain as a fifth vital sign, establishing clear protocol, building in accountability standards, and improving insurers' ability to pay for alternative treatments for pain.

Regarding dispensing opioid medication, integration among prescribers, pharmacies, insurance agencies, and technology is important, but Idaho must work to integrate all behavioral health systems. Strategies to improve integration could include promoting the utilization of holistic approaches to pain management and the flexibility in insurance to cover these options, increasing the number of substance use disorder treatment providers and suboxone waivered physicians, using telemedicine to serve rural communities, incorporating recovery coach services to intervene with inmates in jails and prisons, encouraging medical professionals to practice at the upper end of their licenses, and the integrating Veteran Affairs (VA) and state public health policies and protocols.

In addition to limiting the supply of opioids through the above listed strategies, Idaho must also work to improve individual protective factors; family support services should be expanded. Faith-based and school-based resources and programs, home visiting programs, programs specifically for veteran, and other family-based programming would improve protective factors and reduce risk factors for later opioid use.

VII. Existing Prevention and Recovery Initiatives in Idaho

The state of Idaho's Naloxone access law required that ODP and DHW create and maintain an online education program for lay persons and the general public relating to opioid-related overdoses. ODP adapted four separate Naloxone training videos, two in Spanish, two in English, to provide information on both injection and nasal methods of Naloxone administration. The videos are housed on ODP's and the DHW's websites. Total view counts for the videos, as of July 20, 2017, are as follows:

Video	Views
English (Injection):	324 views
English (Nasal Spray):	265 views
Spanish (Injection):	98 views
Spanish (Nasal Spray):	94 views

ODP partnered with an internist in the Boise area to develop a Naloxone presentation that is adaptable to educate a variety of audiences. As of July 20, 2017, ODP had conducted eight (8) of these trainings for medical providers, prevention professionals, and the Idaho Behavioral Health Board leadership committee.

The state of Idaho does not house an official registry of individuals or entities trained in overdose education and Naloxone administration.

VIII. Policy & Legislation Proposed or Enacted in Idaho Related to the Opioid Overdose Crisis; including the Overall Socio-Political Environment that is Supportive of MAT

Idaho is a very conservative state. Priding itself on agriculture and the great outdoors, you will frequently hear that "Idaho is a pick-yourself-up-the-bootstraps state" in the halls and session rooms of the State Capitol. Idaho takes a very conservative approach to social service provision, emphasizing local community and faith responses to need, rather than "another government program" saving the day. In this same vein, the Idaho State Legislature is not keen on accepting federal mandates and has, more than once, fought back in the court room over such mandates. In this environment, it is no surprise that Idaho has not expanded Medicaid. IDHW, along with its many partners, has put significant amount of effort into educating lawmakers, the public and just about anyone else who will listen on the fact that addiction is a disease and we must treat it as such.

Accessing MAT using public funding is difficult in Idaho. Medicaid is currently the only public payor we are aware of that reimburses for MAT services, but they will only reimburse for Suboxone/Buprenorphine for pregnant women. The access is further limited by the number of patients a doctor can prescribe for.

A recently acquired SAMHSA grant will introduce publicly-funded MAT to Idaho by adding Methadone and Suboxone to the array of treatment and recovery support services that are currently available. Individuals with Opioid Use Disorder (OUD) who are eligible for Substance Use Disorder (SUD)-related services will be able to access these medications at various locations throughout the state. This will be accomplished by increasing the number of Suboxone and Methadone providers in Idaho, training traditional treatment providers in evidence-based treatment models focused on OUD, and by creating a system in which OUD specialty clinical treatment providers can refer individuals to MAT services. Through the MAT program, IROC will seek to provide services to no less than 250 Idahoans per year who are in need of medication.

i. Overview of Policies and Legislation Over the Last Several Years:

2014

- Passed legislation requiring prescribers to register for access to the Prescription Monitoring Database.

2015

- Passed legislation to enable pharmacists prescriptive authority of opioid antagonists. Any person or entity can now possess an opioid antagonist.

2016

- Passed legislation to enable delegate access to the PDMP. Delegates may search on behalf of a prescriber or dispenser in their usual course of business
- Passed legislation to enable coroner and medical examiner access to the PDMP
- Changed PDMP program policy to allow access through PMP Gateway®

2017

- Passed legislation mandating pharmacists must register to access the PDMP
- Passed legislation enabling the Board of Pharmacy to schedule drugs in rule upon a change in DEA schedule
- Adopted regulations on reporting time frame for PDMP. All controlled substances must now be reported by the end of the next business day.
- Adopted rules to require reporting of controlled substance dispensing from any outpatient drug outlet – including emergency departments and prescriber drug outlets.
- Adopted regulations allowing drug takeback programs in accordance with federal law.
- Adopted regulations allowing partial fills of schedule II drugs in accordance with federal law.

Legislation passed in 2015 made Naloxone available to anyone in Idaho by simply asking their pharmacist. The bill allows people suffering from a drug use disorder or their friends and family members to obtain Naloxone. It also allows for pharmacists to prescribe Naloxone directly so patients can access it without first having to go to a traditional prescriber. Under Idaho's Good Samaritan Law, the Naloxone statute shields anyone who administers Naloxone from liability if the person receiving it calls 911. Idaho law also affords liability protections for pharmacists and other prescribers who initiate Naloxone. As Idaho allows pharmacists to prescribe Naloxone, standing orders for Naloxone and listed guidance for it are not needed.

IROC funding will be used to increase the use of Naloxone to reverse opiate overdoses through training and provision of Naloxone to first responders and other community members (including FQHCs) who may come in contact with individuals at risk of opiate overdose. This will be accomplished by identifying a minimum number of first responder agencies that will begin carrying Naloxone, community and provider trainings, and by providing Naloxone kits to identified and trained entities.

The Opioid Misuse and Overdose Workgroup mentioned above was created by the governor's task force. The Workgroup met earlier this year at a two-day conference to address a Strategic Plan. The group has since met once and will be meeting monthly to address the current crisis and short and long term tactics. In addition, the ODP has established a Prescription Drug Abuse Workgroup which has worked on introducing and passing legislation surrounding the use and availability of Naloxone as well as other prevention tactics throughout the state.

IX. The Current Evidence-Based, Evidence-Informed, and Promising Practices in Place for Prevention Efforts in Idaho

i. Media Campaigns, including Intended Audiences and Messages

Lock Your Meds Idaho

ODP, in partnership with the former Prescription Drug Workgroup, secured funding for the Lock Your Meds campaign through the Millennium Fund. The campaign was delivered statewide through TV, radio, bus ads, billboards and digital advertising. The campaign targeted adults 35+ with teenagers living in the household to "be aware, don't share, lock up your meds" to prevent diversion among youth. The campaign evaluation showed that over 66 percent of Idahoans heard the message which changed storage habits for 16 percent. The evaluation also showed a statistically significant increase in concern of risk among parents of teenagers.

Naloxone Brochures

ODP developed a tri-fold brochure for anyone who may benefit from having Naloxone administration kits on hand; including but not limited to family members or friends of individuals who misuse opioids, individuals who misuse opioids, emergency medical services personnel, treatment providers, social workers, and other behavioral health workers. The brochure message includes recognizing the signs of overdose, administering Naloxone, obtaining Naloxone, and understanding opioids and their risk.

ii. Other Funded Programs Addressing the Opioid Crisis, i.e. PDO, SPF-RX, and Medication Drop Off Sites

The Secure and Responsible Drug Disposal Act of 2010 was enacted to allow ultimate users to transfer prescription medications to retail pharmacies for disposal. However, while retail pharmacies are well suited to collecting unwanted, unused, or expired prescription medications, only five retail pharmacies out of 286 in Idaho have installed prescription drug drop boxes. The Idaho State Pharmacy Association attributes this to significant program startup costs and pharmacies have agreed that the main deterrent from collecting unused, unwanted or expired prescription medications is the initial costs associated with the program.

The Idaho Division of Public Health received a grant under the CDC's Prescription Drug Overdose: Data-Driven Prevention Initiative funds. The Prevention in Action component of the grant is designed to directly target the problem of prescription drug misuse and overdose, by focusing on the Idaho Prescription Drug Monitoring Program (PDMP). Both functionality and utilization of the PDMP are targeted. Improvements to the functionality of the data system include the application of software which will allow the Idaho PDMP to interact directly with prescribers' electronic health records, and a pilot trial of NARxCHECK, an analytics engine that automates access to PDMP data and analyzed it for multiple factors that are indicative of potential risk of prescription drug misuse. In addition to the improvements to the system, utilization increased by specific educational efforts to train prescribers in the use of the PDMP.

iii. Strategic Prevention Framework State Incentive Grant (SPF SIG)

The SPF grant is a pass-through grant of approximately $100,000 each year for five years awarded to 16 substance abuse prevention coalitions statewide. The funding is used to address prescription drug misuse in communities through mobilizing resources and stakeholders to implement environmental strategies. Environmental strategies utilized by the coalitions include, but are not limited to collaborating with law enforcement for DEA drug take-back days and establishing permanent drug take-back programs, educating the public via programs and campaigns, conducting town halls, and developing policy initiatives. Additionally, the SPF SIG funds eight (8) law enforcement agencies conducting a range of prevention activities. One law enforcement agency was funded to develop a prescription drug task force.

Prescription Drug Overdose: Data-Driven Prevention Initiative (funded by the Centers for Disease Control & Prevention)

The DDPI grant program aims to help states advance and evaluate actions implemented to address opioid misuse, abuse, and overdose. The Department of Health and Welfare, Division of Public Health received the DDPI grant to carry out the following actions:

- Identify currently available resources and key state-level stakeholders
- Conduct a needs assessment of key stakeholders, facilitated by ODP, to better understand the prescription opioid and heroin misuse landscape
- Convene key stakeholders for a strategic planning meeting to review and discuss gaps and to discuss prescription drug monitoring and misuse prevention. This meeting will be facilitated by the Idaho Prescription Drug Workgroup with support from ODP. The workgroup includes multiple state-level stakeholders with a strong interest in prescription drug abuse prevention (detailed in the Collaborations section below)
- Develop a strategic plan to improve public health access and use of Idaho Board of Pharmacy PMP data for public health surveillance and improving opioid prescribing practices in the state of Idaho
- Develop a plan, implemented jointly with partners, to improve PMP utilization, meaningful use, unsolicited reporting and public health application of PMP data statewide and perform routine collection, analysis, and dissemination of data from the PMP and other key sources.
- Identify areas in the state with increased opioid prescribing that can the focus of targeted interventions to change/reduce prescribing practices
- Improve coroner reporting practices
- Fund prescribers and pharmacists to implement Gateway which provides direct access to the PDMP into their electronic medical records
- Fund all Idaho local public health districts to provide prescriber education, directly by health educators, and by identifying physician champions to provide peer-to-peer education.

Millennium Fund

The State of Idaho used tobacco settlement money to create the Millennium Fund and the joint legislative Millennium Fund Committee. The Committee awards to state agencies and community organizations annually, through a competitive grant process, to carry out substance abuse prevention and treatment programs.

ODP received funding from the Millennium Fund to implement the Lock Your Meds media campaign for state fiscal year 2014. Further ODP, in collaboration with the Idaho Board of Pharmacy, was awarded a grant to develop a mini-grant program for retail pharmacies to implement drug take-back programs.

iv. School and Community Education Programs

Truth 208

Truth208 is a youth prescription drug misuse media campaign and education series that reveals the truth about prescription drug misuse. The messaging focuses on making adolescents and teens aware of the harms of prescription drugs through TV, radio, bus ads, billboards and digital advertising. Additionally, an education component is available for Idaho schools, juvenile detention facilities, and drug courts to bring in speakers to present factual information on prescription drug use.

Truth 208 has also implemented the environmental strategies of establishing drug take back programs in 46 law enforcement locations statewide, hosting take back days in each public health district, and providing free posters and rack cards in English and Spanish to the public.

v. The Location of Prevention Efforts

Geographically

To ensure funding is proportional, the Office of Drug Policy uses an established formula to determine the allocation of Substance Abuse Block Grant (SABG) Primary Prevention funds. An initial base award of $50,000 is made to each of the seven public health district regions. The remaining available trustee and benefit funds are divided based upon the most recent population data per region. For example, our least populated region receives 9% of available funds, while our most populated region receives 25% of available funds.

The Office of Drug Policy funds 16 community coalitions across the state, in each of the seven health districts, which must address prescription drug misuse in their communities. Despite regional coverage, there are areas that could benefit from additional prevention services.

Per the Bureau of Vital Records and Health Statistics, between 2013 and 2015 Bonneville and Bannock County had significantly higher drug-induced mortality rates compared to the state rate. Although not all drug-induced deaths are opioid-related, nationally approximately 6 out of 10 drug-related deaths are opioid-related (Rudd et al., 2016).

In addition to these two counties, researchers have identified rural populations being at a considerably higher risk for opioid misuse than more urban areas. These differences have been, in part, explained by greater distance to health care professional, which may increase opioid prescribing to offset burden of travel; migration of young adults to urban areas; greater opportunity for networking which may facilitate diversion; and economic stressors (Keyes et al., 2014). Idaho's rural and frontier communities warrant special consideration when planning a response to Idaho's opioid crisis

Systematically

Systematically, there are several areas of unmet needs in prevention. Methadone clinics do not report dispensed methadone to the PMP. Although division is difficult to quantify with current measures, lack of reporting to the PMP exacerbates the issue. The VA is also not required to report to Idaho's PMP. As an already vulnerable population is subject to administrative loopholes and differences in policy and procedures, it is more likely that veterans are at disproportionate risk of misusing opioids.

As previously mentioned, complementary and alternative medicine, including physical therapy, are solutions often underutilized for chronic pain. Providing a greater abundance of alternative services in rural communities and connecting pain specialists and general practitioners with the information they need to make referrals to these services would increase utilization.

Ultimately, without individuals available to implement strategies to the public, it is likely that the opioid issue will persist. Idaho has a very limited substance abuse prevention workforce. According to a workforce development survey administered by ODP in 2016, approximately 36% of the prevention workforce in Idaho provides services for less than 5 hours per week and 15% have not had any training in the last two years. Additionally, over 66% of Idaho's prevention workforce is over the age of 45, which emphasizes a great need for recruitment.

X. The Existing Recovery Support Initiatives in Idaho, including a Description of their Current Involvement and Capacity for Addressing the Opioid Crisis

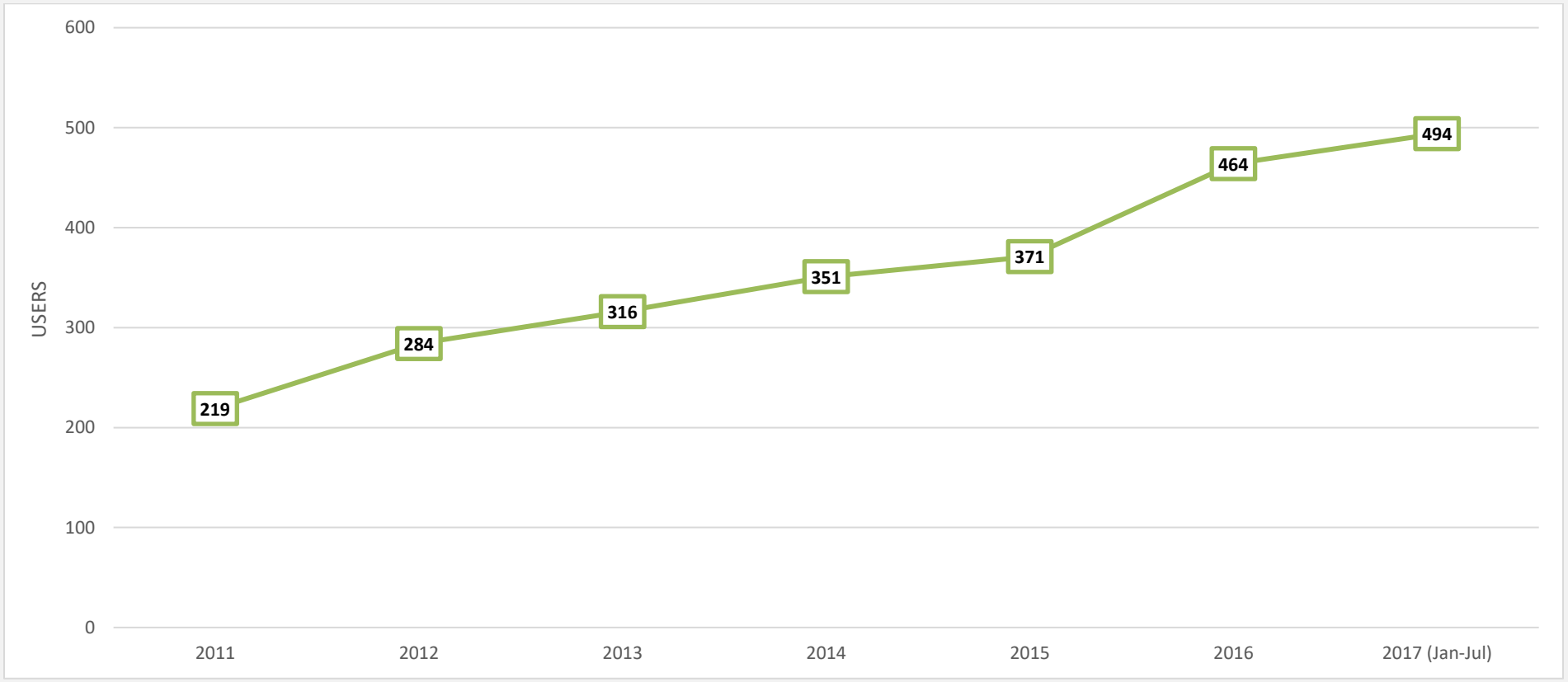
Recovery Community Organizations

Recovery Idaho (RI) is Idaho's umbrella recovery community organization. While still in its infancy, RI is working to provide Recovery Coach training across the state, support Idaho's 7 recovery centers and advocate against stigma. Idaho's seven (soon to be eight) recovery centers are in every region of the state. These centers are also very new yet already provide an immense amount of resources and support for those individuals seeking to adopt a life style of recovery. Most centers are struggling with securing on-going funding to keep the doors open. The centers are modeled after the Connecticut Community for Addiction Recovery (CCAR) centers located in Connecticut, offering services such as: support groups, networking, smoking cessation, employment support, sober activities, etc.

Idaho has over 500 trained recovery coaches. We also have a IC&RC affiliated certification for recovery coaches. The SABG, along with the Idaho Department of Corrections currently reimburse for these services; Medicaid does not.

XI. Persons Served with Public and Private Funds in DATA 2000 Buprenorphine Waiver Provider Practices (including FQHCs) in Idaho

Idaho Medicaid Buprenorphine and Buprenorphine/Naloxone Utilization (2011-2017)



Idaho Medicaid Buprenorphine and Buprenorphine/Naloxone utilization has increased consistently since 2011.

Division of Medicaid (September 2017)

Total Number of Persons Served with Private Funds

Idaho does not have the capability to track the total number of persons served with private funds at this time.

XII. Other Existing Activities and their Funding Sources in Idaho that Address Opioid Use Prevention, Treatment, and Recovery Activities

While Idaho is most definitely experiencing a significant increase in opiate and heroin use, misuse, and death, the opiate epidemic here has not yet reached the proportions that other states in the Midwest and East Coast are facing. Thus, coordinated efforts to combat this epidemic are just now coming to fruition in this state.

The funding offered through SAMHSA's State Targeted Response has shed a lot of light on this serious issue and, thus, many individuals and entities are showing an interest and wanting to become involved.

Partnerships are being formed on an on-going basis. These partnerships will be invaluable as we move forward toward getting our arms around the problem…before Idaho's epidemic hits the epic proportions that other states are experiencing.

XIII. Discussion and Conclusions

i. Indicators of Heroin and Non-Heroin Opiate/Synthetic Use, Misuse, and Dependence

Non-Heroin Opiate/Synthetic Use

Since reaching a peak in 2010-2012, much of the data we have identified appears to show a modest decrease in non-heroin opiate/synthetic use in Idaho.

The percentage of total admissions to Idaho's publicly funded Substance Use Disorder Treatment Network in which opiates other than heroin were listed as the primary reason for admission decreased 1.15% from Fiscal Year 2015 to FY2016 and 1.08% between FY2014 and FY2016. In total, opiates other than heroin were associated with 8.68% of admissions (774 of 8,916) in Fiscal Year 2016 which represented a 1.22% decrease from FY2015 and a 1.69% decrease from FY2014. Between '05 and '14, the percentage of Idahoans reporting past year nonmedical use of prescription pain relievers (NMUPPR) on the National Survey of Drug Use and Health decreased by 33%. Idaho has also remained slightly below the national average in NSDUH-reported lifetime use of prescription drugs without a doctor's prescription, though the difference is not significant.

These trends suggest that it is possible some improvements in opioid prescribing practices throughout the state are being reflected in indicators of non-heroin opiate/synthetic use. Another indication of desirable opioid prescribing practices is that prescribing has been shown to increase steadily with age in Idaho, which is consistent with a general increase in the prevalence of chronic pain with age (as would be expected).

Nevertheless, as SAMHSA recently showed an increase in opioid misuse among older adults (age 50+) in The CBHSQ Report (Opioid Misuse Increases Among Older Adults; July 25, 2017), future monitoring of this age-related trend and older age-group may be warranted. Additionally, ARCOS [a database of controlled substance transactions reported to the DEA] saw that in 2016 Idaho was above the national average for the rate of opioids dispensed per 100,000 population. The retail distribution of fentanyl in Idaho is also above the national average and has increased since 2006. This demonstrates that there is still work to be done in Idaho and a significant need to improve prescribing practices throughout the state.

Heroin Use, Misuse, and Dependence

While non-heroin opiate use has shown a decreasing trend since 2012, Idaho appears to have seen an even faster increase in heroin use over the same period per the data we have identified. Several indicators of heroin use, misuse, and dependence have increased alarmingly in Idaho over the past decade.

Past year heroin misuse and dependence increased by 67% between 2003 and 2014 on results of the National Survey on Drug Use and Health, however the same study saw that the rate of Idahoans who misused heroin or were dependent on heroin and did not receive treatment at a specialty facility decreased by 33% over the same period. This suggests the increase in heroin use is also associated with increased treatment at specialty facilities and the trend was reflected in admissions to Idaho's publicly funded Substance Use Disorder Treatment Network.

Heroin was associated with 16.69% of admissions to Idaho's publicly funded Substance Use Disorder Treatment Network in Fiscal Year 2016 which represented a 3.76% increase from FY2015 and a 5.90% increase from FY2014. The percentage of total admissions in which heroin was listed as the primary reason for admission likewise increased 2.42% from FY2015 to FY2016 and 3.97% from FY2014 to FY2016. While total admissions to Idaho's Substance Use Disorder Treatment Network decreased significantly from FY2015 to FY2016, total heroin-related admissions increased.

In addition, between 2007 and 2015, the heroin arrest rate in Idaho increased 13-fold. Though increases were seen in the heroin arrest rates across several Idaho counties over the same period, drawing conclusions based on this data is difficult as the limited population size of many counties can cause any increase to drastically change the rates.

Drug Overdose Deaths

Drawing conclusions from Idaho's opioid-involved death reporting is difficult for several reasons.

- First, the types of drugs involved with drug-induced deaths are underreported statewide and thus the true number of opioid-involved overdose deaths is likely higher than what is observed.
- Second, certain counties (including some of Idaho's most populated) have an especially large percentage of drug deaths with no drug(s) specified on the death certificate. Our analysis found 11 Idaho counties in which more than half of drug-induced deaths did not have a drug specified during the observation period. As a result of this substantial underreporting, the true number of opioid-involved overdose deaths may be particularly impacted in these counties. The lack of consistent reporting throughout the state also makes comparisons across counties difficult.
- Finally, drawing conclusions based on the rate of opioid-involved overdose deaths is difficult in Idaho as the small population size of many counties can cause even one death to drastically change the rates observed.

The most recent data available regarding drug overdose deaths appears to show that while rates have increased in Idaho since 2010, Idaho remains slightly lower than the national average. In 2015, Idaho ranked 34th in the age-adjusted rate of drug overdose deaths by state. It is estimated that more than half of all drug deaths were associated with an opioid (62.0%).

From 2012-2016 there were 1,140 drug-induced deaths among Idaho residents. Of the 1,140 deaths, 752 death certificates (66%) did specify one or more drugs. Of the 752 drug-induced deaths in which the death certificate specified the type of drug or drugs, 466 (62%) specified one or more opioid drug(s). Corresponding to its large population size, Ada county had the largest gross number of drug-overdose deaths with opioid drugs specified on the death certificate from 2012-2016 (154 deaths).

Since 2011 the proportion of opioid-related drug-induced deaths attributed to heroin appears to have increased significantly, while overall the number of deaths per year has remained fairly consistent year-to-year. It is unclear if this trend is related to the apparent increase in heroin use described above, or possible changes in reporting resulting in an increase in documentation of heroin on the death certificate.

Providing education and resources to county coroners to improve the accuracy of reporting drugs involved in drug-induced deaths, and ensuring consistent documentation of these drugs, would improve monitoring of drug overdose deaths in Idaho and allow for more accurate analysis of data and trends.

ii. Identified Gaps in Treatment and Services

Current Programmatic Capacity and Policy/Legislation Proposed or Enacted within your State/Jurisdiction Related to the Opioid Overdose Crisis Including the Overall Socio-Political Environment that is Supportive of MAT

Accessing MAT using public funding is difficult in Idaho.

There are only three Opioid Treatment Providers which provide methadone as a Medication Assisted Treatment, all located in the same county (Ada). These OTPs do not currently receive any state or federal funding. Individuals receiving services through these agencies must be able to pay out of pocket for medications and counseling or have insurance that will cover them.

Medicaid is presently the only public payor that reimburses for MAT services and will only reimburse for Suboxone and Subutex for pregnant women. Access is further limited by the number of patients a doctor can prescribe for.

A recently acquired SAMHSA grant will introduce publicly-funded MAT to Idaho by adding Methadone and Suboxone to the array of treatment and recovery support services that are currently available. Through the MAT program, IROC will seek to provide services to no less than 250 Idahoans per year who are in need of medication. IROC funding will be used to increase the use of Naloxone to reverse opiate overdoses through training and provision of Naloxone to first responders and others (including FQHCs) and other community members who may encounter individuals at risk of opiate overdose.

Reporting to the PMP

Methadone clinics do not report dispensed methadone to the PMP, and the VA is also not required to report to Idaho's PMP. This makes many measures difficult to quantify.

Complementary and Alternative Medicine

Providing a greater abundance of alternative chronic pain solutions and services, such as physical therapy, in Idaho's rural communities and connecting pain specialists and general practitioners with the information they need to make referrals to these services would increase utilization.

Substance Abuse Prevention Workforce Shortages

Over half of Idaho's prevention workforce is over the age of 45, which emphasizes a great need for recruitment. In addition, approximately 36% of the prevention workforce in Idaho provides services for less than 5 hours per week and 15% have not had any training in the last two years. Idaho needs an expanded substance abuse workforce to implement strategies to the public.

Rural and Frontier Counties

On average, clinicians in Gem, Elmore, and Oneida counties wrote schedule II opioid prescriptions for a significantly higher number of average daily MMEs per prescription when compared to other counties between 2015 and 2016 per the Idaho Board of Pharmacy. Gem, Butte, and Washington counties, meanwhile, had a significantly higher percentage of clinicians who prescribed on average 100 MMEs or more per schedule II opioid prescription according to the same Idaho Board of Pharmacy data. Additionally, the CDC classified 13 of Idaho's 44 counties in their highest category of opioids prescribed per person (959-5,543 MME per person) including: Boundary, Shoshone, Nez Perce, Washington, Gem, Valley, Lemhi, Butte, Twin Falls, Cassia, Oneida, Bear Lake, and Caribou.

As seen in the table below, Frontier counties appear to be over-represented in measures of potential opioid overprescribing practices (based on the data identified above) as 8 of the 14 counties highlighted (57.14%) have a density classifying them as Frontier (i.e., less than seven persons per square mile), while Frontier counties comprise only 43.2% of Idaho's 44 total counties. In addition, 3 frontier counties (Butte, Oneida, and Washington) had more than one indicator of high opioid prescribing. Meanwhile, our analysis failed to show high opioid prescribing in any of Idaho's 3 urban counties.

County	Density (residents per square mile)	Designation
Bear Lake	6.1	Frontier
Boundary	8.6	Rural
Butte*	1.2	Frontier
Caribou	3.9	Frontier
Cassia	9.1	Rural
Elmore	8.5	Rural
Gem*	29.8	Rural
Lemhi	1.7	Frontier
Nez Perce	46.9	Rural
Oneida*	3.5	Frontier
Shoshone	4.8	Frontier
Twin Falls	41.6	Rural
Valley	2.7	Frontier
Washington*	6.9	Frontier

Designation	Counties	% (Of Noted Counties) n=14	Total Counties	% (of Total) n=44
Frontier	8	57.1%	19	43.2%
Rural	6	42.9%	22	50.0%
Urban	0	0.0%	3	6.8%
Total	14	100.0%	44	100.0%

* more than one indicator of high opioid prescribing

This data suggests that Frontier counties, in particular, may be at risk for opioid overprescribing and could warrant special consideration when planning a response to Idaho's opioid crisis. This data is consistent with what researchers have seen nationally, as rural populations have been identified as being at a considerably higher risk for opioid misuse than more urban areas. These differences have been, in part, explained by greater distance to health care professional, which may increase opioid prescribing to offset burden of travel; migration of young adults to urban areas; greater opportunity for networking which may facilitate diversion; and economic stressors (Keyes et al., 2014).

The current substance abuse prevention system in Idaho to address the opioid crisis is a collaborative, multi-disciplinary effort aimed at employing evidence-based prevention strategies and public policy initiatives. It has many strengths including the use of a variety of evidence-based practices in prevention education. However, it is clear there is still room to improve prescribing practices, especially in Frontier counties. Prescribers could benefit from additional education regarding evidence-based prescribing guidelines unintended consequences of inappropriate prescribing practices, effective PMP usage, and holistic or alternative options for treatment that do not include opioid prescriptions. There is also a need for reinforcing prescribers who check the PMP; use the PMP data strategically; and maximize the value of the PMP, which may include the addition of reportable fields such as patient diagnosis; and integrating the PMP and electronic medical records.

Regarding dispensing opioid medication, Idaho must work to integrate all behavioral health systems. Strategies to improve integration could include promoting the utilization of holistic approaches to pain management and the flexibility in insurance to cover these options, increasing the number of substance use disorder treatment providers and suboxone waivered physicians, using telemedicine to serve rural communities, incorporating recovery coach services to intervene with inmates in jails and prisons, encouraging medical professionals to practice at the upper end of their licenses, and the integrating Veteran Affairs (VA) and state public health policies and protocols.

Again, it is difficult to draw conclusions based on opioid-involved mortality data in Idaho as the small population size of many counties can cause even one death to drastically change the rates and percentages that are observed. As such, we cannot fully determine from this data whether rural and frontier counties are disproportionately impacted by opioid-related deaths. However, there does not appear to be a significant association between county population and underreporting of drugs involved in drug-induced deaths. Among the 11 Idaho counties in which more than half of drug-induced deaths did not have a drug specified over the period we examined, the distribution of rural, frontier, and urban counties is not significantly different than what would be expected.

Designation	Counties	% (Of Noted Counties) n=11	Total Counties	% (of Total) n=44
Frontier	5	45.5%	19	43.2%
Rural	5	45.5%	22	50.0%
Urban	1	9.1%	3	6.8%
Total	11	100.0%	44	100.0%

County	Density (residents per square mile)	Designation
Bonneville	57.8	Rural
Camas	1.0	Frontier
Canyon	338.7	Urban
Caribou	3.9	Frontier
Cassia	9.1	Rural
Elmore	8.5	Rural
Fremont	6.9	Frontier
Gem	29.8	Rural
Lemhi	1.7	Frontier
Minidoka	26.8	Rural
Oneida	3.5	Frontier

Hispanics/Latinos

Although higher past 30-day use of prescription drugs was not seen among this demographic, a significantly greater percentage of Hispanics reported that there was no or slight risk in using prescription drugs not prescribed by a licensed medical provider, per the Idaho Behavioral Risk Factor Surveillance System in 2014. As such, prevention strategies should be culturally competent and tailored to Idaho's Hispanic population. Rural counties located in the southern half of Idaho are comprised of particularly high concentrations of Hispanic persons, and consequently represent areas where culturally-tailored support is principally needed. Canyon County in the southeast region of the state has the largest overall Hispanic population.

Serious Mental Illness and Opioid Misuse

Adults with serious mental illness (SMI) appear to be at a greater risk of misusing opioids than adults in the general population. Based on SAMHSA statistics and the 2014-15 National Survey on Drug Use and Health, there are over 8,000 adults in Idaho estimated to have both serious mental illness and opioid misuse in the past year. This corresponds to 0.73% of all adults in Idaho, higher than the percentage seen nationally (0.6%). With 13.0% of those who misused opioids also suffering from SMI (and, alternatively, 15.6% of those with SMI misusing opioids) this small but significant population should not be neglected in Idaho's response to the opioid crisis. Again, Idaho must continue to work to integrate all behavioral health systems throughout the state.

Adolescents, Young Adults, and Public Knowledge

Our results consistently show that adolescents and young adults in Idaho are a particularly high risk population for heroin and non-heroin opiate/synthetic use, misuse, and dependence.

In Idaho, 11th and 12th grade students were significantly more likely to have reported prescription drug misuse than 9th and 10th grade students based on the High School Youth Risk Beahvior Survey in 2015. From 10th to 11th grade the percent of Idaho adolescents who reported having ever took a prescription drug without a doctor's prescription jumped significantly from 13.4% to 21.4%. Young adult Idahoans age 18-25 were the most likely age group to report past year nonmedical use of prescription pain relievers according to the 2013 to 2014 National Survey on Drug Use and Health. 8% of those ages 18-25 reported misusing prescription pain relievers, as opposed to just 4% of the general adult population (age 18+) in Idaho. Subsequently, (based on these estimates and SAMHSA statistics) combined SMI and opioid misuse is also estimated to be more prevalent in young adult Idahoans than in the general population of adults age 18 and older. Finally, in 2014, results showed that those aged 20 to 24 had the highest age-adjusted heroin-related arrest rate in Idaho, significantly higher than their peers of all other age groups.

Evidence-based practices in prevention are currently used by the substance abuse prevention system in Idaho in education targeting youth. Activities conducted include administering evidence-based direct services in schools, juvenile detention centers, and community centers. In addition, Truth208 is a youth prescription drug misuse media campaign and education series that reveals the truth about prescription drug misuse, and an education component is available for Idaho schools, juvenile detention facilities, and drug courts to bring in speakers to present factual information on prescription drug use. Lock Your Meds Idaho was a media campaign targeting adults 35+ with teenagers living in the household to prevent diversion among youth. The campaign evaluation showed that over 66 percent of Idahoans heard the message which resulted in changed storage habits for 16 percent. The evaluation also showed a statistically significant increase in concern of risk among parents of teenagers. Ideally, these results should be reflected in future YRBS and NSDUH studies.

While the above youth-targeted education practices are already making strides in addressing opioid use amongst adolescents and young adults, continued effort should be made to improve the public's knowledge of opioid-related topics to correct perceptions of the opioid issue and improve the public's ability to influence other effective strategies, including policy change. Particular attention should be provided to education addressing middle school and early-high school students and their families, as the High School Youth Risk Behavior Survey demonstrated that the period between 10th and 11th grade is a critical time for adolescents in Idaho to begin using prescription drugs without a doctor's prescription. Attention should also be directed towards improving prevention strategies aimed at Idahoans aged 18-25, a group which has been historically shown to be difficult to reach, especially those who do not choose to attend a university.

In addition, counties with significant populations of young Idahoans represent areas where support could potentially be particularly beneficial. Ada county has the largest gross number of adolescents and young adults, while Madison county has the highest rate of adolescents and young adults per 1,000 persons.

OPIOID NEEDS ASSESSMENT

IROC
Idaho's Response to the Opioid Crisis